Tennessee Department of Mental Health and Developmental Disabilities

2004 Community Mental Health Services Block Grant Plan

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CONTEXT
Description of the State Mental Health System

In response to the 1986 Public Law (PL) 99-660 (now PL 102-321) requiring an examination of the mental health system, a master plan of services was developed with statewide involvement from consumers, family members, advocates, providers, and state leaders. The Tennessee Department of Mental Health and Developmental Disabilities (DMHDD) master plan provided a philosophy of services and a compass for establishing community-based mental health services to address the needs of priority population individuals receiving care through the public sector.

On January 1, 1994, a Center for Medicaid and Medicare Services (CMS) waiver program began to provide medical services previously covered by Medicaid under a new managed care program called TennCare. On July 1, 1996, mental health and substance abuse services were brought under the managed care umbrella. This health care reform provides medically necessary services through a managed care program, which is implemented by Managed Care Organizations (MCOs) and Behavioral Health Care Organizations (BHOs). The Bureau of TennCare administers the program.

While the mental health master plan was displaced by the move to managed care, the requirements for stakeholder participation and a philosophy of services remain a cornerstone of the service system. Current mental health law requires that DMHDD prepare and maintain a three-year plan, which is to be revised annually, for all mental health and developmental disabilities services and supports for the state. The service system is to be based on the following vision and mission statements.

VISION: People with mental illness, serious emotional disturbance, or developmental disability have a quality life based on their individual needs and choices.

MISSION: The mission of the DMHDD is to plan for and promote the availability of a comprehensive array of quality prevention, early intervention, treatment, habilitation, and rehabilitation services and supports.

State Mental Health Authority Leadership

DMHDD contracts with BHOs for services under the TennCare Partners Program (TCPP) and with thirty-six community organizations to provide a variety of services in the areas of education, early intervention, prevention, housing, co-occurrence, criminal justice, suicide prevention, recovery, and support. The Department also oversees a number of federal grants that provide for initiatives in the areas of criminal justice, homelessness, systems of care, housing, and disaster planning and response.

The Department identifies, advocates, and plans for adults with serious and/or persistent mental illness (SPMI) and children and youth with serious emotional disturbance (SED). Our focus is on integration of multi-agency funded services to provide appropriate service components that are designed to meet behavioral health needs along a continuum from education and prevention to rehabilitation and recovery.

The Office of Managed Care (OMC) within the DMHDD works closely with the Bureau of TennCare on priority population definition, contract language, enrollment criteria, marketing and educational material development, best practices, data collection, and adequacy of provider networks.

New Developments

In May 2002, a revised five-year CMS Medicaid waiver created three components of the TennCare program and required a redetermination of TennCare eligibility.

- TennCare Medicaid (TCM) provides coverage to Medicaid eligible persons. All persons meeting any of the various eligibility criteria for Medicaid are covered under TCM. As of June 30, 2003, 76% of priority population adults and children and youth were enrolled in this category.

- TennCare Standard (TCS) provides coverage for uninsurable or uninsured persons who do not have access to insurance, are not eligible for Medicaid, and meet other qualifying criteria related to residency, income, and medical eligibility. As of June 30, 2003, 24% of priority population adults and children and youth were enrolled in this category as uninsured or uninsurable.

- TennCare Assist, a program to help low-income families pay for employer-sponsored health insurance, remains on-hold pending funding.

During FY02, there were 1.6 million individuals enrolled in TennCare for some period of time. As of June 30, 2003, that number dropped by approximately 385,000 to just under 1.3 million. It is noted that the approximate percentage of TennCare enrolled adults with SMI (10%) and the percentage of TennCare enrolled children and youth with SED (4%) remains unchanged between FY02 and June 30, 2003.

Services System Review

In February 2003, the Commissioner of DMHDD established a Leadership Team charged with 1) reviewing the way mental health services are delivered in the state, and 2) determining what works, what is not working, and recommending methods to improve service delivery. Workgroups focused on one of four key areas:

- Access and Capacity – Who should receive services, how, and from whom.
- Funding – Total dollars needed and how they should be allocated.
- Services and Supports – The actual services one would receive in the system.
- Integration – How the mental health system interacts with other systems.

The review is being conducted in four phases. A Phase One report is expected to be submitted to the Commissioner by fall 2003.

Future System Concerns – Attempts to Address

- *There is no retroactive coverage of services to the date of application for non-Medicaid eligible individuals. Determination for TCS eligibility is made within 45-90 days:* A "state-only" category of eligibility was created for uninsured priority population persons requiring immediate services. As of June 30, 2003 services were provided to 2,887 persons in the "judicial or state-only" category.

- *The IMD (Institutes of Mental Disease) payment for services provided at state and free-standing psychiatric hospitals for patients ages nineteen to sixty-four will be removed within three years:* DMHDD staff have met with representatives of the private IMDs and the Tennessee Health Association to formulate the best approaches to these problems. The Services System Review Leadership Team also will address this issue.

- *Early Periodic Screening Diagnosis and Treatment (EPSDT):* The Bureau of TennCare provides numerous tools (including on-site availability) to assist in the goal of EPSDT assessments for all eligible children through the Caring for Kids program. Resources include information for parents, caregivers, physicians, pediatricians, and dentists on early screening and assessment procedures. Guidelines have been published for developmental, behavioral, emotional, and hearing and vision screening processes.

FY03 Areas of Attention & Accomplishment

- *Continue Title 33 Mental Health Law revision training, rule promulgation, and amendment activities:* TDMHDD provided five training sessions on Title 33 and held public rulemaking hearings on twenty-one chapters of rules, nine of which became effective in FY03.

- *Determine and plan for impact of TennCare reform.* (Addressed above.)

- *Continue expansion of housing through the Creating Homes Initiative (CHI):* Added 1,456 units with an additional $29,842.995 dollars leveraged.

- *Implementation of the Cultural Competency Strategic Plan to strengthen cultural competence of the mental health system:* Currently funding mental health training for ethnic stakeholders and training for providers in the use of interpreters.

- *Begin implementation of the Co-occurring Disorders Task Force recommendations:* DMHDD, jointly with the Bureau of Alcohol and Substance Abuse Services, has applied for a State Incentive Grant for Treatment of Persons with Co-occurring Substance Related and Mental Disorders.

- *Expand TCPP and other funded services data analysis via CMHS Data Infrastructure Grant activities and the State Mental Health Planning Council's Service Planning & Oversight Committee (SPOC):* SPOC began meeting in February 2003 and has reviewed TCPP data, Block Grant allocations per region, and a summary of statewide needs assessment information submitted.

- *Examine and promote the appropriate use of telemedicine to provide mental health, specialized, and integrated services:* A TennCare policy on the use of telemedicine was drafted, billing codes established, and strategies for startup funding are being developed. Televideo use for forensic evaluations is being explored.

- *Increase and improve DMHDD web-based information:* TennCare eligibles reports, progress reports, community services directory, and other resource information has been added to the DMHDD website (http://www.state.tn.us/mental). The 2004 Block Grant Plan will be added this year.

FY04 Areas for Attention

- Continue Title 33 revision implementation process.

- Continue expansion of CHI – "2,005 more housing options by 2005".

- Continue implementation of the Cultural Competency Strategic Plan to strengthen cultural competence of the mental health system.

- Continue efforts to build co-occurring disorders service infrastructure.

- Explore funding opportunities to examine and promote the appropriate use of telemedicine to provide mental health, specialized, and integrated services.

Tennessee System of Planning & Policy Councils

Title 33 of the Tennessee Code Annotated (mental health and developmental disability law) requires a structured planning process with three layers of council participation. All three levels are advisory and require the majority of membership to be current or former service recipients and family members. Title 33 requires the DMHDD, on the basis of planning and policy council recommendations, to prepare and maintain a three year plan for all mental health and developmental disability services and supports, including services and supports provided or funded by private service providers of all kinds.

The purpose of all councils is to assist in planning a comprehensive array of high quality prevention, early intervention, habilitation, and treatment services and supports and to advise the Department on policy, budget requests, development and evaluation of these services and supports. The three council layers consist of:

1) DMHDD Statewide Planning & Policy Council (DPPC);
2) State Developmental Disabilities Planning & Policy Council (DDPC) and State Mental Health Planning & Policy Council (SMHPC); and
3) Regional DDPCs and Regional Mental Health Planning & Policy Councils (RMHPCs) in seven DMHDD planning regions.

➢ Role of the DPPC

The DPPC is comprised of no less than seventeen members, not including ex officio members, with a Governor-appointed Chair. The Council consists of legislative representatives and Commissioner-appointed current or immediate past members of both the DDPC and the SMHPC. The total membership must consist of service recipients or family members of service recipients, representatives of children, service providers, advocates, and a representative for elderly service recipients. The Council meets quarterly. Major responsibilities are:

- To conduct an annual review of the adequacy of Title 33 to support the service system;
- To advise the Commissioner as to plans and policies to be followed in the service system and the operation of the DMHDD's programs and facilities;
- To recommend to the General Assembly legislation and appropriations for such programs and facilities; and to advocate for and publicize the recommendations;
- With Commissioner, to report annually to the Governor on the service system, including DMHDD's programs, services, supports and facilities. The DPPC may furnish copies of such reports to the General Assembly with recommendations for legislation and may make other reports to the Governor and General Assembly; and
- To review and make recommendations on the DMHDD three year plan;

➢ Role of the SMHPC

The DMHDD Commissioner appoints members of the SMHPC based on federal membership requirements and council nominations submitted to the Governor's Office of Appointments. Six present or past members of the SMHPC serve as members of the DPPC. To achieve inter-related communication and work among and between councils, four delegates from each of the seven regional councils serve on the SMHPC. The Council meets quarterly.

The SMHPC serves as the state's formal mental health advisory council in accordance with Section 1914 of PL 102-321 and Title 33 of the Tennessee mental health law. The basic duties of the SMHPC are:

- To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state;
- To review Tennessee's annual comprehensive plan for community mental health services and submit to the state any recommendations for modifications to the plan;
- To serve as an advocate for adults with SPMI, children with SED, and other individuals with mental illnesses or emotional problems;
- To advise the DPPC on the three year plan including the desirable array of prevention, early intervention, and treatment services and supports for service recipients and their families, and such other matters as the Commissioner or DPPC may request.

The SMHPC serves in an advisory capacity to the DMHDD and the DPPC. It is the central coordination point for monitoring regional mental health activities and gathering and reviewing regional recommendations to the Department.

SMHPC Committees include the TennCare Partners Roundtable (TCPR), which formalizes a process that brings consumers and family members, service providers, state agency decision-makers, and BHO representatives to the table monthly to examine TCPP issues of concern. The TCPR oversees TCPP implementation, data studies, and proposed changes. The Roundtable makes recommendations for service improvements and prepares reports to the Governor and to CMS as requested.

Other Planning Council working committees include Advocacy and Public Education, Children and Youth (C&Y), the Consumer Advisory Board (CAB), Co-occurrence, Criminal Justice, Cultural Competence, Employment, Housing & Homeless, Older Adults, and the Service Planning & Oversight Committee (SPOC).

- Role of the RMHPC

Tennessee was the first state to initiate regional implementation committees for PL 102-321. These groups ensure that regional needs and issues are brought to the state level. The DMHDD Commissioner appoints members based on regional council nominations. Chairpersons and three other representatives, including one consumer and one family member, serve as delegate members to the SMHPC. The RMHPCs meet, at a minimum, quarterly.

SMHPC and RMHPC activities for FY04 will focus on the TCPP waiver impact, inpatient utilization, system capacity, service access, identification of service gaps, an assessment of regional transportation needs, and assuring service availability for those most in need.

- SMHPC Contributions

Council members are actively involved in the development, implementation, and monitoring of all facets of mental health activities. DMHDD enjoys and appreciates a cooperative and productive working relationship with Council members and their affiliate groups. The SMHPC continues a tradition of not only advising and advocating for the strengths of Tennessee's mental health service delivery system, but actively and cooperatively participating with DMHDD to improve the system.

This process targets stakeholder's prime concerns and positions the Council to present prioritized issues to the DPPC and the various state departments. The statewide and regional planning council network directly involves approximately 300 stakeholders in the planning, monitoring, and evaluation process.

Areas of Attention for FY03 and Accomplishments

- *Address the unique mental health needs of older adults:* Grant to support statewide mental health and aging coalition to educate stakeholders about the unique mental health issues of older adults.
- *Increase Council involvement in annual plan criteria information, evaluation, and performance indicator development:* Established SPOC to assist the SMHPC in the monitoring, review, allocation, and evaluation of DMHDD contract services.

- *Continue efforts to increase attendance and participation of consumers and caregivers of children with SED in regional and state mental health councils:* Extended membership criteria to "caregivers" rather than just parents of children with SED.

- *Strengthen stakeholder role in the design, implementation, and evaluation of the mental health service system:* The quarterly meeting format accommodates a continuous information loop from Council committees and the seven regional councils. Brief reports are presented and members vote on whatever issues are raised. Discussion and disposition of prioritized issues follow.

- *Participate with the newly-formed DPPC and the Developmental Disabilities Council to realize their purposes:* Reports from SMHPC members serving on the DPPC are made. DMHDD staff share regional council development and coordination strategies with Developmental Disabilities staff.

Areas of Attention for the FY04 SMHPC

- Restructure and streamline the Council's monitoring and advisory function.
    - Regional Planning Councils submit needs assessment results to SPOC.
    - SPOC submits services review and needs assessment report to the SMHPC.
    - SMHPC submits prioritized needs assessment data to DPPC where advisory information with budget implications is submitted to DMHDD for inclusion in the three year plan.

- Host National Association of Mental Health Planning and Advisory Council (NAMHPAC) technical assistance visit to increase Council membership knowledge base, enhance understanding of Council purpose, and improve productivity.

- Continue recruitment of caregivers of children and youth with SED as Council members. A contract to the Tennessee Respite Coalition has been awarded to assist with this initiative.

- RMHPCs will develop local transportation plans with the goal of assisting individuals with mental illness to conduct business, meet appointments, and participate in other activities necessary for independent community living.

Critical Gaps and Unmet Needs

Through an on-going assessment process, service need projections are submitted to the Division of Mental Health Services from the regional and state mental health planning councils and their committees. Behavioral health needs assessment data flows from regional planning councils to the SPOC for review and prioritization. The Committee then forwards recommendations to the SMHPC, which in turn makes recommendations on needed services to the DPPC. DMHDD, in determining priorities for funding services and budget requests, considers these recommendations, along with desired state and national initiatives.

While some needs assessment data is specific to certain regions of the state, the following broad areas of unmet needs have been identified:

1. Integration of services for those with co-occurring disorders.
2. Increased employment opportunities for adults with SPMI.
3. Increased outreach to homeless adults and family populations.
4. Increased housing options for priority and special populations, including transitional housing for persons discharged from inpatient care and financial support for supervised group homes.
5. Need for criminal justice liaisons to cover all local jail systems.
6. Improve transportation options, especially in rural areas.
7. Increase array of school-based education, prevention, and early identification services, including day care consultation and after-school services.
8. Create transitional services to prepare youth for transition to work, school, and adult living, including orientation to adult treatment and support services.
9. Increase support groups and services for adults, family members, and caregivers.
10. Increase crisis and planned respite resources for adults, children, and caregivers.
11. More Assertive Community Treatment (ACT) teams.
12. Increased residential and inpatient beds for children.
13. Resources for dental and eye care.
14. Improved cultural competence of system of care.

Results from a TCPR C&Y Committee survey in July 2003 indicated a strong need for an integrated and coordinated system of care for children with mental health, substance abuse, and co-occurring disorders. The top ten service needs listed were:

System of Care	Referral and Advocacy
In-home services	Crisis Respite
Parent Support Groups	Psychological Evaluation
Parent Education	Planned Respite
Family Therapy	Individual Therapy

Critical advancements in many of these areas have occurred within the past few years. Since 1996, DMHS has been able to utilize federal grants and state funding to provide an array of education, early identification, and intervention services for children, and supplemental support and recovery services for adults. In addition, initiatives in housing, co-occurrence, health care integration, criminal justice, school-based services, and care coordination have been accomplished.

The continuation of these services and the development of additional resources to meet critical gaps are dependent upon national economic stability, increased state and federal budget allocations, and an adequate, coordinated community provider network.

Tennessee's success in maintaining current service levels and continuing development of community mental health system resources will be dependent on future legislative budget actions and federal Medicaid waiver impact.

Community Mental Health Services Block Grant

Adult Services Plan

July 1, 2003 – June 30, 2004

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DMHDD ORGANIZATION CHART

DMHS ORGANIZATION CHART

OFFICE OF MANAGED CARE ORGANIZATION CHART

Criterion 1
A Comprehensive Community-Based System of Care

Organizational Structure of the System of Care and Structural Changes

The system of care for adults with mental illness consists of three service delivery entities: TennCare/TennCare Partners for medically necessary medical and behavioral health care services for Medicaid eligible adults and others meeting criteria as uninsured or uninsurable; DMHDD contract services for support, recovery, and model program development; and the Department of Health (DOH), Bureau of Alcohol and Drug Abuse Services (BADAS), for education, early intervention, and non-TennCare covered substance abuse treatment services.

A Commissioner heads the State Mental Health Authority. The Commissioner of DMHDD is a cabinet-level position and, as such, has direct access to the Governor. TennCare, a responsibility of the DOH, Bureau of TennCare, is administratively responsible to the Department of Finance & Administration (DFA). The Office of Managed Care (OMC) within DMHDD oversees contracting for the TennCare Partners Program (TCPP), which provides for managed behavioral health care services through a variety of community providers. The Division of Mental Retardation Services is administratively responsible to the DFA.

An Assistant Commissioner leads the Division of Mental Health Services (DMHS). The DMHS administers five state operated Regional Mental Health Institutes (RMHIs) and contracts with community mental health providers and other agencies to provide services and support initiatives complementary to the medically necessary clinical services provided under managed care. DMHS staff provide advocacy, planning, service development, program monitoring and evaluation, budget monitoring, and technical assistance for non-TennCare community support programs and forensic services.

DMHDD maintains mental health licensing responsibilities and oversight of the forensic services contract for adults and juveniles. In addition, DMHS is responsible for investigations at RMHIs and complaint resolution for consumers, family members, legislators, and the public.

No structural changes have occurred within DMHDD since submission of the 2003 Block Grant application.

System of Treatment, Rehabilitation, and Support Services

- **Mental Health Services**

TennCare Partners

As of April 1, 2003, the Basic Benefits package (available to all enrollees) and the Enhanced Benefits package (available only to priority population adults) were blended. Currently, access to any TennCare Partners service is accomplished by meeting the medically necessary criteria for that service. “Medically necessary” is defined on the following page.

"Medical assistance services or supplies provided by an institution, physician, or other provider that are required to identify or treat a TennCare enrollee's illness, disease, or injury and which are:

a) Consistent with the symptoms or diagnosis and treatment of the enrollee's illness, disease or injury; and
b) Appropriate with regard to standards of good medical practice; and
c) Not solely for the convenience of an enrollee, physician, institution or other provider; and
d) The most appropriate supply or level of services which can safely be provided to the enrollee. When applied to the care of an inpatient, it further means that services for the enrollee's medical symptoms or condition require that the services cannot be safely provided to the enrollee as an outpatient; and
e) When applied to enrollees under 21 years of age, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989." *(Source: TennCare Contract, Amendment 5)*

Services Include:

- Inpatient Psychiatric Treatment
- Outpatient Mental Health Services
- Inpatient and Outpatient Substance Abuse Treatment Services (10 days detox and $30,000 lifetime limit for non-priority population enrollees)
- Pharmacy and Laboratory Services
- Transportation to covered services as medically necessary for enrollees lacking accessible transportation
- Mental Health Case Management
- 24-Hour Residential Treatment
- Housing/Residential Care
- Specialized Outpatient and Symptom management
- Psychiatric Rehabilitation Services

<u>Specialized Outpatient Services</u>

- Crisis Services: A statewide 24/7 response to psychiatric crises in the adult general population, including a mandatory prescreening function to assess eligibility for emergency involuntary admission to a state hospital facility and rule out less restrictive alternatives in the community.

- Crisis Respite: A function of the crisis services intended to provide a safe environment for individuals who cannot stay in their homes during a crisis, and who otherwise might be hospitalized. Adult respite services are encouraged to employ consumers as respite care staff members.

- Crisis Stabilization Unit: A non-hospital facility-based service that offers twenty-four (24) hour intensive mental health treatment for short term stabilization for persons whose psychiatric condition does not meet the criteria for involuntary commitment to a psychiatric hospital or other treatment resource.

- Continuous Treatment Team Services: An intensive form of integrated treatment that includes a coordinated group of staff members who provide a range of clinical treatment, rehabilitation, and support services twenty-four hours per day to adults with SPMI meeting a high-risk criteria. (Includes three Comprehensive Community Care teams, one PACT team, and one Forensic ACT team.)

- Forensic Evaluation and Treatment Services: Court ordered outpatient and inpatient evaluation of mental health and competency status.

➢ **Rehabilitation Services**

- Drop-In Centers (DIC): Consumer-operated centers open to all adult consumers of mental health services. Consumers develop their own programs to supplement existing mental health services, address issues such as social isolation and discrimination, and provide opportunities for socialization, personal and educational enhancement, and peer support.

- Psychosocial Rehabilitation: Consumer-centered strengths-based model program of services for adults with SPMI to improve functioning, rather than treat symptoms of a mental illness. Service participants, in partnership with staff, form goals for skill development in the areas of vocational, educational, and interpersonal growth that serve to maximize opportunities for employment and successful community integration.

➢ **Employment Services**

- Vocational Programs: The primary purpose is to provide services or activities that facilitate work at a job or training site of the consumer's choice. Services may include, but are not limited to, supported employment, psychosocial rehabilitation, pre-vocational work units, vocational work assessments, job readiness training, and enclaves.

➢ **Housing Services**

- HUD group homes and supported apartments.

- Supported Living Facilities: A permanent housing facility that provides supervised room, board, and personal care services for adults with SPMI.

- Assisted Living: Clustered apartment units, with one unit occupied by a live-in "assisted living specialist". The specialist is a consumer whose role is to serve as a mentor to and provide support for the other residents. The goal is to assist the consumer in a smooth transition to independent living.

- Supported Housing: Congregate living with scheduled on-site mental health staff assistance that offers support or teaches independent living skills. Without this type of assistance, the service recipient would not be able to maintain independent living.

- Creating Homes Initiative (CHI): Increase funding leverage to develop a continuum of housing options for persons with disabilities.

- Independent Living Assistance: Provides priority population consumers with initial and supplemental utility and rent deposits to enable individuals to maintain housing of their choice.

➢ **Medical and Dental Services**

- Primary Care Physician and Specialist Medical Services under TennCare
- Two Mental Health/Primary Care Integration Projects provide an integrated model of assessment and treatment. Staff offer consultation to community mental health agencies and primary care providers interested in replicating this model.
- A portion of independent living assistance funds are available to community providers to access needed medical and/or dental care for priority population adults.

➢ **Educational Services**

- See Psychosocial Rehabilitation and Drop-in Center services.

➢ **Substance Abuse Services**

- Primary alcohol and drug prevention, education, and treatment services are provided through contract agencies of both the BHOs and the DOH, BADAS.

➢ **Case Management Services**

- Mental Health Case Management Services must be offered to TennCare eligible priority population adults assessed as CRG 1 and 2 and are available to others as medically necessary. (See Adult Criterion 2 on pages 54-55 for further description of priority population assessment.)

➢ **Services for Special Populations**

- Services for Older Adults: Four projects offer professional mental health counseling and other support services to adults age fifty-five and over who are homebound or do not access traditional outpatient mental health services. These projects serve to promote collaboration between mental health and the community providers who typically provide services to older adults (e.g., primary care, senior centers) and provide mental health education to family members and caregivers. In addition to these projects, a CMHS grant supports the initiation of statewide mental health aging coalitions.
- Services for Individuals with Co-occurring Disorders (COD): The Co-occurrence Project, a joint effort of DMHDD and the DOH, BADAS, supports a statewide resource center, supports dual recovery self-help meetings, and funds small projects in case management, vocational services and provider education. While not exclusively for consumers with COD, DMHS contracts with Foundations Associates to support a DIC.

  DMHDD, through state and federal grants, funds four agencies to provide or support integrated treatment services for adults with co-occurring disorders of substance abuse and mental illness, including transitional housing and a Dual Diagnosis Recovery Network (DDRN) which promotes education and develops Dual Recovery Anonymous support groups statewide.

The BHO funds three continuous treatment teams for adults with COD. DMHDD made application for a State Incentive Grant for Treatment of Persons with Co-Occurring Substance Related and Mental Disorders (COSIG) for FY04.

- Services for Consumers Interfacing with Criminal Justice System: Criminal Justice liaison staff provide early identification of persons with SPMI within the criminal justice system, promote diversion alternatives to community programs, and provide training and education to enhance collaborative efforts between the criminal justice and mental health systems. Currently, there are seventeen criminal justice projects covering twenty-one counties and a grant to develop a training curricula for mental health and criminal justice professionals on the needs and services for individual with mental illness in the criminal justice system.

- Services for Culturally Diverse Populations: The Cultural Competence Committee, in collaboration with the System of Care Council, completed a strategic plan for building a culturally competent mental health services system. A demographic study identified the State's diverse cultures, training was completed, and the Cultural Competence Strategic Plan was endorsed by the SMHPC. Current focus is on mental health training for ethnic minority individuals within their communities and training for providers in access and appropriate use of interpreters.

- Services for Homeless Populations: Outreach/case management services are provided for mentally ill adults who are homeless in eight locations statewide. Permanent Housing sites provide housing for homeless individuals and families with mental illness in three locations statewide.

- Services for Deaf and Hard of Hearing: DMHDD staff and one representative member of the SMHPC explore mental health services needs and resource development from the perspective of the deaf and hard of hearing community. Staff provides consultation to community providers and managed care organizations concerning interpreter availability and additional community resources. A DMHDD staff person also serves on the board of the Tennessee Council for the Deaf and Hard of Hearing. Special accommodation notices are included in State and Regional Council meeting announcements and interpreters are provided as needed. The BHO requires contract providers to assure interpreters as needed.

➢ **Other Support Services**

- Compeer: The Compeer Program provides socialization to adults with SPMI. A compeer volunteer helps individuals integrate into the community and access its resources and activities. (This service is currently limited to one location.)

- Consumer Support Services: This service provides assistance to develop and sustain local consumer support groups across the State, including development of BRIDGES (Building Recovery of Individual Dreams and Goals through Education and Support) consumer-taught education groups.

- Family Support Services: This service involves assistance to establish and maintain family support and advocacy groups for family members of persons with psychiatric disorders, including the development of Journey of Hope (JOH) educational classes for relatives of individuals with a mental illness.

- Statewide suicide prevention hotline, support groups, and staff training in suicide prevention.

Monitoring of Contract Services

DMHS-contracted services are monitored by DFA on a schedule based on assessed agency risk and budget constraints. Attainment of performance measures is verified during the site visits by observation, documentation, and/or reports. Programs are monitored for compliance with contracted budget and scope of services. Corrective action plans must be submitted for areas of non-compliance. DFA forwards completed monitoring reports to DMHS for review.

DMHS staff provide technical assistance as needed and/or requested. The performance measures are continuously evaluated for improvements, with the goal of attaining more outcome-oriented measures. DMHS Planning Committee staff and members of SPOC will review outcome measures and make recommendations for improvement.

BHOs monitor contract agencies for compliance with service provision, attainment of performance measures, and effectiveness of community services. A yearly consumer satisfaction survey is also conducted. TennCare Partners services are monitored by the Bureau of TennCare, the DMHDD OMC, and the TennCare Partners Roundtable.

Access and Eligibility Issues: Behavioral Health Managed Care System

Tennessee has identified several areas in order to address concerns regarding access to care. These areas include the following:

- TennCare eligibility, including assessments to define the priority population;
- Access indicators;
- Inclusion of key services which provide specialized access to care;
- Consumer Information/Ombudsman Service; and
- Utilization Management Protocol including adequate due process protections.
- Early Periodic Screening, Diagnosis and Treatment Services

In order to address issues related to access to care, the following indicators of access are tracked:

- the number of clients served;
- the number and types of service units provided;
- the location of service sites;
- the timeliness of services;
- ability to access emergency, urgent and routine services; and
- provider capacity.

These indicators provide information regarding an enrollee's ability to access care within a reasonable distance and timeframe. In addition, the state gains critical information regarding service utilization and penetration rates. The contract between the State and BHOs specifies access requirements for each service category. Further, the blending of the benefits packages allows access to specialized services such as case management to anyone meeting the medically necessary criteria for that service.

➢ TennCare Access

Persons may apply for TennCare eligibility at their local Department of Human Services (DHS) office at any time; however, if not Medicaid eligible, enrollment in TCS has certain limitations. To be eligible for TCS as "uninsured", TennCare enrollment must be open. To be eligible for TCS as "medically eligible", the following criteria must be met:

1. Current assessment as SPMI
2. Qualifying medical diagnosis
3. Health insurance denial option (uninsurable)
4. Income no greater than 100% of poverty

Medically necessary behavioral health services may also be provided under a state-only designation. Adults assessed as SPMI (see Adult Criterion 2 on pages 54-55) who meet the poverty guidelines may be enrolled for coverage of needed behavioral health services. State-only eligibility assessments are completed at state mental health institutes and community mental health agencies. State-only status ends when the enrollee becomes eligible for TennCare or other insurance.

➢ Key Services

A second door of access lies within the availability and comprehensiveness of the benefit package. Currently, the TCPP offers a generous benefits package including mental health services that increase access to care.

- Mental Health Case Management: Mental health case managers serve as the agent for linking priority population individuals to mental health, primary health care, and other needed services. Mental health case management services consist of the following components: assessments and prioritization of needs; service plan development; linking the individual and his/her family with necessary community resources and support groups; assistance in daily living; referral to other community services; advocacy; crisis response; and monitoring the overall service delivery plan.

- Crisis Response Services: Crisis services function as an effective portal of entry to the mental health system, particularly for individuals who have not yet been identified as needing services. Crisis response services are accessible to persons of all ages regardless of TennCare eligibility. The BHOs coordinate one widely published toll-free telephone number for any individual in the general population for immediate phone intervention by mental health staff and dispatch of mobile crisis services in the appropriate community.

- Symptom Management: Needed outpatient services may be provided in the community in the individual's natural environment, such as home, school, shelter, etc. The TCPP covers this service.

Consumer Information/Ombudsman Service

Within any system of care, individuals will experience times of difficulty or misunderstanding when attempting to access services, whether for themselves, their child, or a family member. A statewide toll-free information line, the TennCare Partners Advocacy Line, and a toll-free number maintained by the DMHDD Office of Consumer Affairs and Advocacy receive and respond to calls from 8:00 AM until 4:30 PM, Monday through Friday.

Utilization Management Protocol and Due Process Protections

Utilization management is based on the definition of "medically necessary" on page 42. Utilization management protocol defines guidelines for service admission, continued stay, and discharge.

In order to protect an individual's due process rights, Tennessee has established a clearly defined appeals process under the TCPP, including timeframes for resolution. Protective measures include an expedited review process, inclusion of independent reviewers, including an administrative law judge review, enrollee education regarding appeal rights, and close state oversight of the appeals process. The TennCare Solutions Unit maintains and publicizes toll free numbers (including a line for persons speaking Spanish and a line for persons with hearing or speech problems) available twenty-four hours per day to assist TennCare recipients with questions concerning getting the healthcare they believe they need when they need it.

Inpatient Utilization

The BHO contracts with twenty-nine inpatient psychiatric facilities to provide inpatient care to adults. Five of these contracted facilities are state RMHIs: Lakeshore Mental Health Institute (LMHI) in Knoxville, Middle Tennessee Mental Health Institute (MTMHI) in Nashville, Western Mental Health Institute (WMHI) in Bolivar, Moccasin Bend Mental Health Institute (MBMHI) in Chattanooga, and Memphis Mental Health Institute (MMHI) in Memphis.

- State Regional Mental Health Institutes

For FY03, the five RMHIs reported 10,177 adults received 13,020 admissions; an average increase of 18% over FY02 with a range among the five RMHIs of 4.3% at MMHI to 36.3% at MBMHI. Of these 10,177 adults, approximately 78% listed the BHO as the guarantor of payment, but it is not known how many were assessed as priority population. (Of the total adult TennCare enrollees assessed as SPMI receiving inpatient psychiatric services during FY02, 39% were served in the five state institutes.)

The RMHIs reported an overall 11.6% readmission rate within 30 days for the period October-December 2002.

- Other Psychiatric Inpatient Providers

During FY02, approximately 61% of TennCare enrollees who received inpatient psychiatric services were hospitalized at one of fourteen private community hospitals. The average overall readmission rate for these facilities during October-December 2002 was 14.7%.

Activities to Reduce Hospitalizations

➢ Inpatient Utilization Review

DMHDD staff closely monitor utilization of the state-operated RMHI beds, tracking trends in admissions, average daily census, length of stay, and readmission rates as compared with the same time period in prior fiscal years.

Overall TCPP inpatient utilization is monitored by the BHO and quarterly reports are prepared and reviewed by DMHDD and the TCPR. Reports include utilization rates per thousand for adults and youth psychiatric and substance abuse inpatient services. Reports are used by the Department, inpatient facilities, and regional stakeholders to monitor the effectiveness of inpatient care, the continuity of service planning, and the adequacy of community services.

For those for whom hospitalization is the most appropriate option, length of stay is impacted by early discharge planning and the timely availability of less restrictive alternatives. Needs for treatment, housing, case management, support groups, and consumer and family education services must be adequately identified and addressed prior to discharge from inpatient care.

➢ Less Restrictive Alternatives to Hospitalization

- Crisis Stabilization Unit: In an effort to provide an alternative to hospitalization, plans were developed to create a crisis stabilization unit in Chattanooga to divert service recipients, when clinically appropriate, from hospitalization. It will serve medically stable adults who present in a psychiatric crisis and are assessed as needing a level of care greater than respite, but less intense than inpatient psychiatric hospitalization. It is anticipated that the crisis stabilization unit will be operational in mid-FY03.

- 24-Hour Walk-in Assessment: There are currently three walk-in triage programs across the state (Knoxville, Chattanooga, and Nashville). Mental health agency crisis service are on site and persons can receive evaluation, medication, and counseling services for up to eight hours.

- Targeted Transitional Support Program (TTSP): This program is designed to assist persons eligible for discharge from the state mental health institutes by enabling them to move to community settings with temporary transitional support (maximum 180 days) until their financial benefits/resources are established. Services that can be provided include housing, rental assistance, supplemental support payments, utilities; medication management services, such as psychotropic medications, doctor's appointments and lab work; transportation to/from scheduled appointments and support services, such as to-and-from day programs, case management and counseling; and other services as required for individual consumers and approved by the RMHI and the community providers.

- Mandatory Prescreening Law: Tennessee mandates a pre-screening evaluation for eligibility for emergency involuntary admission to state mental health institutes. A key element of pre-screening is the determination that all available less drastic alternatives to placement in a hospital are unsuitable to meet the needs of the individual experiencing a crisis.

- Mobile Crisis Response Services: The BHOs contract for crisis response services coverage for every county in Tennessee; respite services are accessed through crisis services.

Further, recovery services that promote peer counseling, consumer empowerment, and community acceptance for adults with SPMI can have a positive impact on an individual's management of his/her illness, the use of crisis services, and need for hospitalization. DMHDD supports, through its contracts, services targeted toward community support and recovery resources for adults.

Legislative Initiatives

DMHDD worked with legislators and law enforcement officials to amend statutes to allow family members, clergy, mental health professionals, and others to transport individuals for emergency hospitalization who do not require security. These are primarily people who are unable to care for themselves or keep themselves safe because of their mental illness.

A major problem area was also addressed in legislative change this year. The Department has been exploring ways to address a shortage of nursing. Legislation was successfully passed to alter the state's personnel practices to provide more flexibility in recruitment, scheduling, and retention of nurses. This will support more full time nurse positions and reduce dependence on contract agency nurses. These changes are expected to improve nursing care in the state hospitals.

PERFORMANCE INDICATOR DESCRIPTIONS

Goal 1: **To maximize the ability to remain in a community setting by providing coordinated service delivery in the most appropriate, least restrictive environment available.**

Objective: To maintain admissions to psychiatric acute care facilities at a maximum of 15%.

Population: Adults assessed as SPMI receiving a TennCare Partners service during FY04.

Criterion: **Comprehensive, Community-Based System of Care**

Brief Name: **I/P Admissions**

Indicator: Percentage of adults with SPMI receiving TennCare services who are admitted to acute inpatient care.

Measure: % Numerator: Unduplicated # of adults with SPMI admitted to inpatient psychiatric acute care

Denominator: Unduplicated # of adults with SPMI receiving a TennCare Partners service

Sources of Information: DMHDD, Office of Managed Care, Research & Analysis Group

Special Issues: An acute care admission is defined as one that results in a hospital stay of less than thirty (30) days.

Significance: A major outcome of a comprehensive, community-based mental health system of care is the reduction of the need for inpatient hospitalization.

Goal 2: **To offer effective inpatient treatment and continuity of care to enable the service recipient to remain in a community setting.**

Objective: To reduce the number of persons readmitted to inpatient care within 30 days.

Population: Adults assessed as SPMI receiving a TennCare Partners psychiatric inpatient service during FY04.

Criterion: **Comprehensive, Community-Based System of Care**

Brief Name: **I/P Readmission**

Indicator: Percentage of adults with SPMI receiving TennCare services who are readmitted to acute inpatient care within 30 days.

Measure: % Numerator: Unduplicated # of adults with SPMI readmitted within 30 days of discharge.

Denominator: Unduplicated # of adults with SPMI admitted to inpatient psychiatric acute care during FY04.

Sources of Information: DMHDD, Office of Managed Care, Research & Analysis Group

Special Issues: Readmission is defined as admission to any inpatient psychiatric hospital within 30 days of discharge from inpatient stay.

Significance: A major outcome of a comprehensive, community-based mental health system of care is the effectiveness of inpatient treatment and the continuity of community care.

Goal 3: **To provide case management services to individuals with SPMI.**
Objective: To maintain case management services to 40-50% of adults with SPMI.
Population: Adults assessed as SPMI receiving TennCare Partners services during FY04.
Criterion: **Comprehensive, Community-Based System of Care**
Brief Name: **Adult CM**
Indicator: Percentage of adults with SPMI receiving TennCare services who receive a mental health case management service.
Measure: % Numerator: Unduplicated # of adults with SPMI receiving a mental health case management service
Denominator: Unduplicated # of adults with SPMI receiving TennCare Partners service
Sources of Information: DMHDD, Office of Managed Care, Research & Analysis Group
Special Issues: Enrollment in case management is voluntary. Consumer service rejection rates may indicate the need for a better approach from the case management provider.
Significance: Assuring access to case management services for adults with SPMI is a primary goal of a community-based service system and a commitment of DMHDD and TennCare.

Goal 4: **To create and expand affordable, safe, permanent, and quality housing options in local communities for people with mental illness in Tennessee.**
Objective: To increase stock of permanent housing options in TN by 500 units.
Population: Adults with disabilities, especially serious mental illness.
Criterion: **Comprehensive, Community-Based System of Care**
Brief Name: **Housing**
Indicator: Number of additional housing options developed during SFY04.
Sources of Information: Office of Housing Planning and Development, Creating Homes Initiative Update
Special Issues: The average cost of a one-bedroom apartment in Tennessee is nearly 80% of the average SSI income.
Significance: Housing remains the number one indicator for psychiatric stability. The lack of safe and affordable housing options impacts inpatient utilization, homelessness, shelter use, and dignity and quality of life issues.

FY04 STATE MENTAL HEALTH PLAN PERFORMANCE INDICATOR
SPMI ADULT DATA TABLE

Criterion: 1. Comprehensive Community-Based System of Care

	SFY 02 Actual	**SFY 03** Projected	**SFY 04** Objective	**%** Attain
Performance Measures:				
1. I/P Admissions*				
Value:	15.8%	N/A	15%	_____
IF Rate:			(or less)	
Numerator	13,392	N/A		_____
and				
Denominator	84,798	N/A		_____
Performance Measures:				
2. I/P Readmission*				
Value:	N/A	N/A	20%	_____
IF Rate:			(or less)	
Numerator		N/A		_____
and				
Denominator		N/A		_____
Performance Measures:				
3. Adult CM*				
Value:	51%	N/A	40-50%	____
IF Rate:			(range)	
Numerator	43,414	N/A		____
And				
Denominator	84,798	N/A		____

** TennCare claims data processing may lag by up to six months; therefore, a full 12-months of data may not be included in numbers shown.*

Performance Measures:				
4. Housing				
Value:	695	1,456	↑500	_____

Criterion 2
Mental Health System Data Epidemiology

Estimate of Prevalence of SMI

The Federal Register notice of June 24, 1999 gives states the methodology to estimate the twelve-month prevalence of persons with serious mental illness (SMI) ages eighteen and older. The criteria used to determine SMI and SPMI populations appear compatible with those used for assessing priority populations in Tennessee.

Table 2.01 shows estimates of SMI using the average state percentage in the study noted above as well as the TennCare enrollment of that population during FY03.

TABLE 2.01 ESTIMATED # OF PRIORITY POPULATION & TENNCARE ENROLLMENT

2000 Census TN Population (18 and over)	Estimated % SMI	Total	SPMI TennCare Enrolled (FY03)*	Penetration Rate for FY03
4,289,719	5.4%	231,645	173,730	75%

** Individuals with a CRG assessment code of 1, 2, or 3 (SPMI) enrolled in TennCare for any period of time during July 2002 through June 2003. Source: Research & Analysis, Office of Managed Care, TDMHDD, August 2003.*

Priority Population Determination for Individuals Eighteen and Over

Adult priority population definition: An individual age eighteen and over who currently has, or at any time during the past year has had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistical Manual that has resulted in functional impairment that substantially interferes with or limits one or more major life activities.

Since 1994, Tennessee has used the Clinically Related Groups (CRG) Assessment tool to determine functional impairment and classify the adult priority population. While DMHDD continues to research a variety of methodologies to determine priority populations, no other method has as yet been adopted.

Community Mental Health Agency (CMHA) and RMHI staff receive training in conducting the CRG assessment. A “Train the Trainer” model in assessment procedures is utilized and designated individuals are responsible for providing training to other agency staff. The BHO conducts training and maintains a current listing of staff certified to conduct priority population assessments.

Assessment staff use the CRG as a tool to record the following:

- the individual's diagnosis(es),
- level of functioning in the areas of activities of daily living; interpersonal functioning; concentration, task performance, and pace; and adaptation to change,
- severity of impairment due to a mental illness,
- duration of severity, currently and previously, and
- need for services to prevent relapse.

Assessment results in one of five classifications as detailed below

CRG 1: Persons with Severe and Persistent Mental Illness: These are persons whose functioning is recently, or in the last six months has been, severely impaired and the duration of their impairment totals six months or longer in the past year.

CRG 2: Persons with Severe Mental Illness: These are persons whose functioning is recently, or in the last six months has been, severely impaired and the duration of their impairment totals less than six months in the past year.

CRG 3: Persons who are Formerly Severely Impaired: These are persons whose functioning has not been severely impaired within the last six months but has been severely impaired in the past and they need services to prevent relapse.

CRG 4: Persons with Mild or Moderate Mental Disorders: These are persons who have been diagnosed with a psychiatric disorder, but have not recently been severely impaired and, are not formerly severely mentally ill, or do not need services to prevent relapse. These individuals primarily need access to outpatient services.

CRG 5: Persons who are not assessed as CRG 1-4 as a Result of Diagnosis: These persons have been diagnosed with a developmental disorder, V-code, or substance use disorder only.

The adult priority population is identified as those with an assessment of CRG 1, 2, or 3: adults with severe and persistent mental illness (SPMI), severe mental illness (SMI), and those assessed as having SMI/SPMI and requiring treatment to prevent relapse.

These adults have been identified as being in special need of continued or specialized mental health and/or substance abuse treatment services (for dually diagnosed individuals with a primary mental health diagnosis) to improve their level of functioning. Services may include community support groups and access to resources that aid in decreasing hospitalization rates and improving one's quality of life.

Eligibility for Behavioral Health Benefits

The basic and enhanced benefits packages were collapsed into a single benefit package on April 1, 2003. Access to all TennCare Partners covered services is based on the medically necessary criteria as defined in Adult Criterion 1 on page 42.

Additionally, persons with an assessment of CRG 1, 2, or 3 who require services and are not eligible for TennCare, may meet eligibility criteria for services as judicial or state-only enrollees.

Quantitative Targets to be Served

- TennCare

Based on encounter data processed to date, 86,451 adults with a CRG classification of 1, 2, or 3 received a TennCare Partners service during FY03.

- DMHDD Contract Services

The network with which the Department contracts to provide mental health services for adults includes sixteen CMHCs and sixteen other community agencies/organizations.

Quantitative targets in each service program funded through the CMHS Block Grant and other state funds not designated to the TCPP are summarized in Table 2.02 on page 57. Noting that a projection of numbers to be served is not applicable to all services, it is estimated that over 43,500 adults with serious mental illness or co-occurring disorders will benefit from DMHDD contract services during FY04.

TABLE 2.02 PROJECTED NUMBER TO BE SERVED THROUGH FY04 FUNDING (BOTH CMHS BLOCK GRANT AND STATE FUNDS)

Service Category - ADULTS	Estimated Number To Be Served *
Co-Occurrence Project for MH/Substance Use Disorder Statewide Training for Providers & Consumers Dual Diagnosis Resource Centers Dual Recovery Anonymous Groups	Not Established
HUD Programs and Permanent Housing	500 consumers
Consumer and Family Support Groups and Compeer	1,000 Individuals
Drop-In Centers	35,000 consumers (based on average monthly attendance at all sites)
Independent Living Assistance	2,000 unduplicated consumers
Criminal Justice/MH Liaison Project	2,000 unduplicated consumers
Older Adult Service Projects	150 consumers
Assisted Living	50 consumers
BRIDGES Consumer Education Classes	900 consumers
NAMI TN Journey of Hope	150 family members
Homeless Outreach (PATH)	990 consumers

* All contracts describe a scope of services, but may not require a projection of number to be served.

PERFORMANCE INDICATOR DESCRIPTIONS

Goal 1: **To maximize access to healthcare coverage for adults in Tennessee, including the portion meeting criteria for SPMI.**

Objective: To enroll a minimum of 60% of the annual estimated prevalence of adults with SPMI.

Population: Adults in the SPMI population without healthcare options enrolled in TennCare at some time during FY04.

Criterion: **2: Mental Health System Data Epidemiology**

Brief Name: **Enrolled**

Indicator: Percent of adults in the estimated priority population that are TennCare enrolled.

Measure: % Numerator: The number of adults enrolled in the TCPP as SPMI

Denominator: Estimated prevalence of SMI in Tennessee

Sources of Information: DMHDD, Office of Managed Care, Research & Analysis Group

Special Issues: The numerator includes the number of individuals enrolled in TennCare at any time during the fiscal year and assessed as CRG 1, 2, or 3.

Significance: The impact of the TennCare waiver changes will not be known immediately. Until impact data is available, maintenance of current enrollment will be the goal.

Goal 2: **To ensure that TennCare enrollees with SPMI have access to community mental health services.**

Objective: To maintain service access to at least 90% of TennCare adult enrollees with a current priority population assessment.

Population: TennCare enrolled adults in the SPMI population during FY04.

Criterion: **2: Mental Health System Data Epidemiology**

Brief Name: **Served**

Indicator: Percent of adults in the priority population that are TennCare enrolled and receiving behavioral healthcare services.

Measure: % Numerator: The number of adults with SPMI receiving a TennCare Partners service.

Denominator: Number of adults with a current SPMI assessment enrolled in TennCare Partners.

Sources of Information: DMHDD, Office of Managed Care, Research & Analysis Group

Special Issues: A current SPMI assessment is defined as an assessment of CRG 1, 2, or 3 within one year.

Significance: Individuals with healthcare benefits can only benefit by ease of access, non-discrimination, and provider availability.

FY04 STATE PLAN IMPLEMENTATION REPORT PERFORMANCE INDICATOR SPMI ADULT DATA TABLE

Criterion: **2: Mental Health System Data Epidemiology**

	SFY 02 Actual	**SFY 03** Projected	**SFY 04** Objective	**%** Attain
Performance Indicator: **1. Enrolled**				
Value:	67.9%	N/A	60% (or more)	_____
IF Rate:				
Numerator	157,350	N/A		_____
and Denominator	231,645❶	N/A		_____

❶ Number based on total projection of 5.4% of adult population (SMI) using 2000 census figures.

Performance Indicator: **2. Served***				
Value:	94%	N/A	90% (or more)	_____
IF Rate:				
Numerator	84,798	N/A		_____
and Denominator	90,109❷	N/A		_____

❷ Unduplicated number of adults enrolled in TennCare during FY02 with a current (within one year) assessment of CRG 1, 2, or 3 (SPMI).

* TennCare claims data processing may lag by up to six months; therefore, a full 12-months of data may not be included in total numbers.

Criterion 4
Targeted Services to Homeless and Rural Populations

Description of the Homeless Populations in Tennessee

In Tennessee, individuals with mental illness who are homeless are defined as those who meet the definition of the priority population for mental illness and who also lack a permanent residence. A permanent residence is defined as a place of one's own where one can both sleep and receive mail.

Identification of homeless populations is a difficult task given that individuals and families may go in and out of homelessness, depending on factors that contribute to their being without a permanent residence. Patterns of homelessness differ between situational, episodic, and chronic and cause fluctuations in determining who the homeless population is at a given point in time.

Gathering reliable statewide information on homelessness is hampered by the lack of common intake and data processes, poor coordination, and uneven technological resources. Information used to determine homeless estimates in this application were taken from Community Development Consolidated Plans, Homeless Coalition surveys and regional county surveys.

National studies suggest that one-third to one-half of homeless individuals suffer from mental illness and/or substance abuse. While a majority of homeless individuals reside in urban areas, the number of rural homeless is largely undercounted. Rural outreach efforts have uncovered a heretofore under-served number of homeless individuals and families in rural areas.

Various surveys have estimated the number of adult homeless persons in Tennessee as between 17,000 and 18,000. Using one estimate that 50% of homeless individuals have a diagnosable mental illness or substance addiction, we can estimate a range of 8,500 to 9,000 persons who are homeless in Tennessee with mental illness or substance abuse issues. Past estimates have indicated that some 65% of the state's known homeless individuals suffer from some form of mental illness or substance abuse disorder.

Outreach and Services to Individuals who are Homeless

The TCPP provides a continuum of services for all eligible individuals with SPMI. Homeless persons who meet the eligibility criteria may receive TennCare using agency addresses, shelter addresses, or Post Office boxes.

Homeless persons who are not TennCare eligible have access to crisis response and intervention services statewide and may participate in no-cost consumer and family support groups and Drop-in Centers at various locations throughout the state.

Over 300 organizations statewide describe themselves as providing a service to some segment of the homeless population. However, only a small number of these have as their primary purpose the provision of services to individuals who are homeless and also have a mental illness.

Independent Living Assistance for initial and on-going rent or utility bill payment is available for priority population homeless adults who receive agency services and wish to seek and maintain housing.

- Services Provided by PATH Grant Agencies (Projects for Assistance in the Transition from Homelessness)

The adult homeless program in Tennessee has two goals: 1) to identify persons who are mentally ill and homeless in the state and 2) to provide the necessary and appropriate services for these individuals.

The foundation of the service delivery system for persons who are mentally ill and homeless is case management. The case managers identify homeless individuals who are mentally ill and assure that they receive appropriate services. In the current fiscal year, Tennessee will receive $565,000 in federal PATH funds and the state supplements these funds with $355,500 state dollars.

PATH funding supports programs in Knoxville, Nashville, Chattanooga, Memphis, Jackson, Clarksville, Murfreesboro, and Johnson City. All PATH grant funded programs provide the following services:

- aggressive outreach to community locations including shelters, food sites, bus depots, vacant buildings, and public areas frequented by the homeless;
- staff scheduling to assure that outreach is conducted at times when homeless use areas are most likely to be occupied;
- case management assessment of needs, service planning, assistance with daily living skills, transportation, crisis intervention, and linkage/referral to needed services and public entitlement programs;
- screening and diagnostic services provided on an outreach basis with access to community mental health providers for outpatient counseling, medication monitoring, symptom management, supported employment, and housing assistance programs; and
- psychiatric crisis intervention available twenty-four hours a day, seven days per week, through the Crisis Response Service covering each respective geographical area.

- Permanent Housing for Homeless Persons Who Are Mentally Ill

In addition to the PATH program, there are three housing programs funded through the federal McKinney Act Permanent Housing for Homeless Program. The state continues to provide some $205,000 in annual support.

The sites are located in three urban areas: Chattanooga, Nashville, and Knoxville. Chattanooga has two sites with housing capacity of sixteen adults. Nashville has four sites with housing capacity for fourteen adults. Knoxville's two sites are dedicated for women and their children.

The goal of permanent housing services is to provide safe and affordable housing to homeless individuals with mental illness.

In addition, DMHDD's Office of Housing Planning and Development (OHPD) targets housing development activities toward the homeless population as follows:

- OHPD, through the Creating Homes Initiative (CHI) process, worked in collaboration with local community groups in the west and east Tennessee regions (both urban and rural) to expand housing options for homeless persons with mental illness.
- The CHI regional housing facilitators generated approximately $6,600,000 of new funds for homeless persons with mental illness across this state.
- The Director of OHPD serves on the Memphis/Shelby County mayor's homelessness task force and has assisted in the development of a nationally recognized blueprint, authorized by Pat Morgan of Partners for the Homeless of Shelby County, to end homelessness in ten years.

Definition of Rural

The U.S. Census Bureau's definition language for rural is "all territory, population, and housing units located outside of urbanized areas and urban clusters". There is no current statistical table to identify "rural" Tennessee counties under this new definition. In Tennessee Statistical Abstract, 1994-95, a county is identified as "rural" if it is 50% or more composed of unincorporated cities of 2,500 or less. The 1990 Census reports seventy-seven of ninety-five Tennessee counties meet the definition of rural. These seventy-seven counties all have fewer than 1,000 persons per square mile.

Services to Rural Areas

- TCPP

  The TCPP policies require equal eligibility, service coverage, and availability statewide to both urban and rural Tennessee residents. TCPP provides a comprehensive continuum of services ranging from acute inpatient care to case management for eligible populations.

  A critical issue for rural residents is their ability to access available services, especially medical health specialists. In the mental health arena, several rural-based CMHAs participate in the federal rural recruitment and retention plan to hire psychiatrists and psychologists. Rural service planning must also take into account the routine travel patterns of rural populations for other services (e.g., shopping, banking, recreational, etc.) to provide convenient access to behavioral health services.

➢ DMHDD

Tennessee augments traditional clinical services with alternative services designed to decrease discrimination, engage isolated individuals, and provide opportunities for peer emotional support, socialization, and education in areas where there are few community resources.

- At least 50% of adult DIC locations are in towns of under 15,000 and 25% are in communities of less than 6,000.

- Three of eight homeless outreach programs for adults are providing services in counties having less than 300 persons per square mile.

- DMHDD assists in funding educational programs that are offered to consumers and family members statewide. The Journey of Hope and Bridges programs are educational and designed by and for family members and consumers. Journey of Hope and Bridges programs are conducted in each of the seven regions of the state to better enable rural consumers and family members to participate.

- DMHDD involves individuals from rural Tennessee in the planning process and has ensured that there is representation from families, consumers, providers, and other advocates from rural areas on the SMHPC, the RMHPCs, and the DPPC. The Department provides travel reimbursement to consumers and family members in an effort to encourage participation at planning council meetings.

PERFORMANCE INDICATOR DESCRIPTIONS

Goal 1: **To provide outreach, assistance and referral to homeless individuals with serious mental illness.**

Objective: To increase the number of homeless individuals contacted through outreach during FY04 who receive homeless case management services by 2%.

Population: Adult homeless individuals with mental illness

Criterion: **4: Targeted Services to Homeless and Rural Populations**

Brief Name: **Homeless CM**

Indicator: Percent of individuals seen in outreach who are enrolled in case management.

Measure: % Numerator: Unduplicated # of outreach contacts enrolled in case management

Denominator: Unduplicated # of outreach contacts

Sources of Information: Annual Report by PATH Agencies to DMHDD

Special Issues: Homeless populations require trust-building over time with staff having a good knowledge of available resources to promote a "one stop shopping" approach to access a variety of needed services.

Significance: Outreach and case management services are available to homeless adults with mental illness to ensure that persons eligible for services are aware of and have access to needed services.

Goal 2: **To ensure access to a continuum of mental health services for populations living in predominantly rural counties.**

Objective: To maintain service access to at least 90% of TennCare adult rural enrollees.

Population: TennCare enrolled adults assessed as SPMI living in rural counties

Criterion: **4: Targeted Services to Homeless and Rural Populations**

Brief Name: **Rural Served**

Indicator: Number of adults in the priority population receiving mental health services as TennCare enrollees living in rural areas

Measure: % Numerator: Unduplicated # of rural county enrollees receiving a mental health service

Denominator: Unduplicated # of rural county enrollees with a current priority population assessment.

Sources of Information: DMHDD, Office of Managed Care, Research & Analysis Group

Special Issues: The low percentage of enrollees receiving a service has been suspect due to an inflated total enrollment figure. Redetermination efforts should allow more accurate data of TennCare enrollees and more current assessment of priority population service activity.

Significance: Assuring access to mental health services for adults with SPMI living in rural areas, especially to encourage use of local resources.

FY04 STATE PLAN IMPLEMENTATION REPORT PERFORMANCE INDICATOR SPMI ADULT DATA TABLE

Criterion: 4: Targeted Services to Homeless and Rural Populations

	SFY02 Actual	SFY03 Projected	SFY04 Objective	% Attain
Performance Indicator: **1. Homeless CM** (Brief Name)				
Value:	68%	N/A	↑ 2%	_____
IF Rate:				
Numerator	1,098	N/A		_____
and				
Denominator	1,600	N/A		_____
Performance Indicator: **2. Rural Served*** (Brief Name)				
Value:	53%	N/A	90% (or more)	_____
IF Rate:				
Numerator	35,647	N/A		_____
and				
Denominator	66,685❶	N/A❷		_____

❶ Unduplicated number of TennCare enrollees with SPMI in rural counties – no determination of current CRG assessment.

❷ Unduplicated number of TennCare enrollees with SPMI with rural counties with a current CRG assessment.

* TennCare claims data processing may lag by several months; therefore, a full 12-months of data may not be included in total numbers.

Criterion 5
Management Systems

Financial Resources

Tennessee made available $362,581,200 in capitation payments made monthly to the BHOs for services provided to TCPP enrollees through June 30, 2003. The State assumed financial responsibility for the cost of all behavioral health pharmacy services to TennCare enrollees in the TCPP as of July 1, 1999 and continues in that role. The pharmacy cost for individuals for FY03 in the community amounted to $391,044,100 with medications for individuals during inpatient stays included in the inpatient rates received by the respective inpatient facilities. The cost of providing forensic and court-ordered evaluations performed at the five RMHIs and in the community is estimated at $24,543,900 dollars.

DMHS funded community mental health services. excluding forensic and court ordered evaluations, at $21,967,400. This funding includes the CMHS Block Grant award and other federal grants received by the DMHS. Further, the five RMHIs expended $17,575,500 above revenue received from the two BHOs to provide inpatient mental health services.

This brings funding for mental health services in Tennessee to $817,712,100 from the Bureau of TennCare and the DMHDD.

The TDCS provided $17,023,512 in funding for community residential mental health service programs for children and adolescents with $1,857,929 of state funds being designated for wraparound services to C&Y in the community through the Child Welfare League of America.

In total, roughly $836,593,541 was directed for the provision of mental health services to individuals within Tennessee for FY03 with the goal for this level of funding to be maintained or increased in FY04.

TDMHDD continues to enter into grant agreements to provide mental health service initiatives outside the scope of services provided under the TCPP. Funds are administered through individual grants with CMHCs and other agencies, various Delegated Purchase Authorities for specific services, and additional interdepartmental funds made available to supplement federal grants awarded to Tennessee.

The 2004 CMHS Block Grant award is $8,316,651. Some $7,900,900, 95% of the total, has been awarded to community based programs in accordance with the expectations of the grant. Approximately 5% of the award, or $415,751, provides administrative support functions relative to the community mental health system.

Staffing and Training for Providers

- DMHDD/DMHS

Staffing:

Despite an ongoing hiring freeze and a projected 200 employee layoff, DMHDD has adequate staff to conduct the business of the department, but limited ability to begin new responsibilities. Staff perform multiple departmental roles and must "pick-up" responsibilities as staff positions are eliminated or shifted and not replaced. Like most states, Tennessee is experiencing a shortage of professional community staff, especially registered nurses and finds hiring and retention of professional staff most difficult within the RMHIs and rural areas. The availability of mental health professionals with clinical expertise in elder care is especially low.

Training:

In addition to routine networking opportunities and technical assistance, DMHDD provides a variety of training related to implementation of grant-funded services to community providers, family and consumer groups, and special grant recipients.

- Funds are provided to conduct Journey of Hope and Bridges educational programs statewide.
- DMHDD provides supplemental funds to support conferences by the Tennessee Association of Mental Health Organizations, the Tennessee Mental Health Consumers Association (TMHCA) and the National Alliance for the Mentally Ill of Tennessee (NAMI-TN).
- DMHDD provides information to consumers, family members, the public, mental health service providers, legislators, and other state agencies on the mental health service delivery system and how to access services.
- DMHDD provides on-going information and orientation about the mental health service delivery system to the SMHPC, RMHPCs, and the DPPC. These training activities assist members in their role of advising DMHDD of service needs, availability, and access issues.
- The Office of Consumer Affairs and Advocacy conducts programs on the rights and responsibilities of TennCare enrollees and provides for cross training of various TennCare advocacy and service groups. Participants include family and consumer groups, MCO and BHO staff, state employees, and advocates.
- DMHDD provides training for peer and mental health staff in the delivery of services to victims of critical incidents and/or disaster.
- Funds are provided to the DDRN to offer professional training on issues of co-occurring disorders (mental health and substance use).
- Mental Health/Primary Health Care Interface and Mental Health Older Adult Projects' staff provide consultations, professional presentations, and community education respective to their project's focus.

Table 5.01 below details routine training activities that will be conducted by DMHDD C&Y Services staff during FY04.

TABLE 5.01 DMHDD Annual Routine Training Schedule for FY04

PROVIDER GROUP	FREQUENCY OF TRAINING
Mandatory Pre-Screening	Four times per year
Mandatory O/P Treatment Providers	Once per year
Forensic Evaluators – Community	Twice per year
Forensic Evaluators – Institute	Twice per year
Drop-In Center Directors	Four times per year
PATH Providers	Four times per year
Criminal Justice Liaisons	Four times per year
Title 33 Training Activities	Five or more

- TennCare

Staffing:

The state contract with the medical and behavioral health organizations requires those entities to maintain an adequate provider base to provide services to individuals covered under the benefit plan. The BHO's outpatient network consists of around 1,000 credentialed and contracted individual and group providers (exclusive of CMHC staff), a small increase from FY02. As of April 2003, the network included the following providers of services for adults.

- 22 providers of 24-hour residential treatment at 80 locations
- 29 providers of inpatient psychiatric services at 30 locations
- 22 providers of inpatient substance abuse services at 27 locations
- 21 providers of crisis response services in 95 counties

Rural recruitment of psychiatrists, psychologists and other licensed master's level professional staff continues to be a problem. Professional staff and network shortages may impact timely access to services and increase waiting lists, causing more emergency admissions.

Some stakeholders report unacceptable wait times to gain intake, clinician, and physician appointments within the mental health service provider community. Telemedicine is utilized for service delivery by a limited number of agencies and funding options for expanding use of this medium are being explored by DMHDD and the BHOs.

Training:

BHO consumer advisory staff provide on-going training and information sessions to inform providers, consumers, family members, and advocates about Tennessee's managed care system.

In order to improve and build upon the skills of providers delivering mental health services, TennCare requires BHOs to offer the following:

1) an educational plan for providers formulated with input from the BHO Advisory Board; (Boards must have minimum 51% family and consumer membership and consumers and family members must be included as trainers.)
2) cross-training of mental health and substance abuse providers;
3) mental health training for primary care providers; and
4) assurance that providers are appropriately licensed, certified, accredited, approved and/or meet DMHDD standards, whichever is appropriate.

Training Providers of Emergency Health Services

Under the TCPP, mental health staff of crisis response services are in regular contact with providers of emergency health services. Crisis services are funded by the BHOs and are available to emergency health staff twenty-four hours a day, 365 days a year. Crisis staff provide on-going consultation and information on mental health crisis intervention strategies and service alternatives. DMHDD provides training in mandatory pre-screening to eligible mental health professionals.

Expenditure of 2004 Block Grant Allocation

DMHDD utilizes its Block Grant funding for the provision of non-clinically related mental health services for adults with SPMI and children and youth with, or at risk for, SED. Services are designed to reduce the use of hospitalization; promote education, prevention, and early intervention; integrate services; and build a reliable community support service system that emphasizes empowerment, recovery, and normalization for individuals and families.

Currently, fourteen private, not-for-profit CMHCs and six other community agencies receive federal mental health block grant funds to provide services to adults. Each contracted agency must provide services in accordance with a specific contract, budget, and scope of services. (Contract agencies may change or others may be added as service contracts are finalized.)

Approximately 67% of the CMHS Block Grant, or $5,324,800, will be allocated for adult services in accordance with Criterion 1, 2, 4 and 5 in the following manner:

Assisted Living Housing **$ 210,000**

- Assisted living fills the gap in the continuum of housing available for adults with SPMI who do not require the supervision of a Supportive Living Group Home, but do not yet possess the necessary skills for independent living. The programs consist of clustered apartment units, with one unit occupied by a live-in “assisted living specialist”. The specialist is a consumer whose role is to serve as a mentor to and provide support for the other residents. The goal is to assist the consumer in a smooth transition to independent living. Funds support six assisted housing projects.

Criminal Justice Project **$ 476,000**

- Projects provide activities targeted toward individuals with SPMI or co-occurring disorders interfacing with the criminal justice system. Services include liaison/case management services, diversion activities, cross-training and education, and appropriate referral and linkage to follow-up services in the community. Goals are to enhance systems collaboration and cooperation, decrease recidivism, and ensure access to appropriate services. Block Grant funds, supplemented by $296,000 in state funding, provide seventeen projects serving twenty-one counties.

BRIDGES Support **$ 250,625**

- Funds are provided to the TMHCA (via the Tennessee Disability Coalition) to support regional advocacy staff and on-going development of the BRIDGES educational program for mental health consumers.

Older Adult Project **$ 316,000**

- The projects provide professional mental health counseling and peer counseling to adults age fifty-five and over who are homebound or otherwise unable or unwilling to access traditional mental health services. Services may be offered in the individual's home or at a primary care site accessed by older adults and staff either provide or refer individuals to the appropriate level of mental health service. Services are provided in collaboration between a CMHC and the aging community service system. Funds support four programs.

Drop-in Centers **$ 4,072,175**

- Consumer-operated sites provide a non-stigmatizing place to meet other consumers of mental health services. Member planned activities provide opportunities for socialization, personal and educational enhancement, and emotional peer support for adults with serious mental illness. Funds support fifty DIC programs in eighty-four counties.

Table 5.02 on page 71 details the proposed 2004 Block Grant contract amounts for adult services by agency and program.

TABLE 5.02 PROPOSED 2004 BLOCK GRANT CONTRACT AMOUNTS FOR ADULT SERVICES

CMHC	Assisted Living	Criminal Justice	BRIDGES Program	Older Adult	Drop-in Center	Total
Frontier	140,000	40,000	0	70,000	470,453	$720,453
Cherokee	0	0	0	0	102,743	$102,743
Ridgeview	0	0	0	0	308,229	$308,229
HR McNabb	0	50,000	0	0	110,243	$160,243
Peninsula	0	0	0	0	185,133	$185,133
Volunteer	0	90,000	0	70,000	976,059	$1,136,059
Fortwood	0	0	0	0	110,243	$110,243
Centerstone	0	105,000	0	106,000	667,827	$878,827
Carey	0	40,000	0	0	205,486	$245,486
Pathways	0	0	0	0	264,358	$264,358
Quinco	0	0	0	0	102,743	$102,743
Professional Counseling	0	0	0	0	205,486	$205,486
Southeast	0	0	0	0	110,243	$110,243
Frayser	0	0	0	70,000	0	$70,000
OTHER AGENCY						
Foundations	0	0	0	0	110,243	$110,243
Friends Helping Friends	0	0	0	0	142,686	$142,686
Mental Health Cooperative	35,000	50,000	0	0	0	$ 85,000
Park Center	35,000	0	0	0	0	$35,000
Shelby Co. Govt.	0	101,000	0	0	0	$101,000
TN Disability Coalition	0	0	250,625	0	0	$250,625
Total Adult	**$ 210,000**	**$ 476,000**	**$ 250,625**	**$ 316,000**	**$4,072,175**	**$ 5,324,800**
					Total C&Y	**$ 2,576,100**
					Total Both	**$ 7,900,900**

	Admin. 5%	**$ 415,751**
	TOTAL BG	**$ 8,316,651**

PERFORMANCE INDICATOR DESCRIPTIONS

Goal 1: **To provide support and recovery-oriented services for adults with SPMI.**
Objective: To maintain the range of funding for recovery-oriented services for priority population adults to 50-70% of Block Grant funding.
Population: Priority population Adults
Criterion: **5: Management Systems**
Brief Name: **Recovery Services**
Indicator: Percentage of block grant funds allocated for recovery-oriented services.
Measure: % Numerator: amount of Block Grant dollars spent on recovery-oriented services
Denominator: total amount of Block Grant funding minus administrative costs
Sources of Information: DMHDD Budget
Special Issues: Allocations based on continued ability to expend Block Grant funding for non-treatment services.
Significance: Non-clinical services, especially recovery services for adults with SPMI, are considered important for maintaining wellness, promoting empowerment, improving access to normalized community resources and contributing to improvements in quality of life.

Goal 2: **To ensure DMHDD-funded programs and services are in compliance with contractual and service performance agreements.**
Objective: To maintain the number of monitored services meeting contract compliance at 95%.
Population: Agencies under contract with DMHDD, DMHS, to provide services for adults.
Criterion: **5: Management Systems**
Brief Name: **Adult Service Compliance**
Indicator: Percentage of contracted programs and services that are in full

compliance with DMHDD contract.

Measure: % Numerator: # of programs/services in full compliance
Denominator: # of contracted programs and services monitored during the previous state fiscal year

Sources of Information: Finance & Administration Compliance Report and Workpapers

Special Issues: While compliance monitoring is under the auspices of F&A, quarterly monitoring reports are submitted to DMHDD for review and follow-up as necessary.

Significance: DMHDD is committed to the provision of quality services and programs. Monitoring of contract agencies helps ensure quality services and is also a tool for providing technical assistance.

FY04 STATE PLAN IMPLEMENTATION REPORT PERFORMANCE INDICATOR
SPMI ADULT DATA TABLE

Criterion: 5: Management Systems

	SFY 02 Actual	**SFY 03** Projected	**SFY 04** Objective	**%** Attain
Performance Indicator: **1. Recovery Services**				
Value:	57%	N/A	50-70%	_____
IF Rate:				
Numerator	$4,342,828	N/A		_____
and Denominator	$7,548,100	N/A		_____
Performance Indicator: **2. Adult Service Compliance**				
Value:	100%	N/A	95%	_____
IF Rate:				
Numerator	17	N/A		_____
and Denominator	17	N/A		_____

Community Mental Health Services Block Grant

Children & Youth Services Plan

July 1, 2003 – June 30, 2004

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Criterion 1- Comprehensive Community-Based System of Care

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Criterion 1
A Comprehensive, Community-Based Mental Health Service System

Organizational Structure of the System of Care and Structural Changes

The system of mental health care for children and youth consists of four service delivery entities: TennCare/TennCare Partners for medically necessary medical and behavioral health care services; the Department of Children's Services (DCS) for children in or at risk of state custody; DMHDD contract services for prevention, early intervention, and model program development; and the DOH, Bureau of Alcohol and Drug Abuse Services (BADAS), for education, early intervention, and non-TennCare-covered substance abuse treatment services.

(Please see additional organization structure information in Adult Criterion 1 on page 41.)

System of Treatment, Rehabilitation and Support Services

- **Mental Health Services**

TennCare Partners

As of April 1, 2003, the Basic Benefits package (available to all enrollees) and the Enhanced Benefits package (available only to priority population children and youth) were blended. Currently, access to any TennCare Partners service is accomplished by meeting the medically necessary criteria for that service or being referred through EPSDT screening services. ("Medically necessary" is defined in Adult Criterion 1 on page 42.)

Services Include:

- Inpatient Psychiatric Treatment
- Outpatient Mental Health Services
- Inpatient and Outpatient Substance Abuse Treatment Services
  (10 days detox and $30,000 lifetime limit for non-priority population enrollees)
- Pharmacy and Laboratory Services
- Transportation to covered services as medically necessary for enrollees lacking accessible transportation
- Mental Health Case Management
- 24-Hour Residential Treatment
- Specialized Outpatient and Symptom management

Specialized Outpatient Services

- Crisis Services: A specially contracted statewide 24/7 response to psychiatric crises of children and youth under age eighteen, including a mandatory prescreening function to assess eligibility for emergency involuntary admission to a state hospital facility and rule out less restrictive alternatives in the community.

- Crisis Respite: A short-term service designed to provide care for children during a time of family crisis. This service is available on a twenty-four hour basis to provide immediate shelter to children and adolescents with SED who require care outside of their homes with the expectation of returning to the family after the crisis abates. May be facility or family based.

- Continuous Treatment Team Services: Integrated treatment that includes a coordinated group of staff members who provide a range of clinical treatment, rehabilitation, and support services twenty-four hours per day to children with SED meeting a high-risk criteria. (Includes Comprehensive Child and Family Treatment teams.)

- Regional Intervention Program (RIP): A program designed for the early treatment of children with moderate to severe behavior disorders who have not yet entered first grade. At least one parent (or other adult) and one child from each enrolled family are required to participate in the program a minimum of two times per week.

- Infant Stimulation: A model to prevent child abuse and neglect for children ages two to five. The service is targeted for parents who have been identified as at "high risk to abuse." The program format includes infant stimulation, parent training through modeling, demonstration, implementation, and direct feedback in a group setting and in the homes of clients. Parents are helped to implement parenting skills related to the child's cognitive, language, and emotional status. (This service is limited to one location and no longer contracted through DMHDD.)

- Day Care Consultation: This is a consultation, training, and referral service for preschool children in day care settings. This service intervenes with preschool children with behavior problems at the point at which these behavior problems become obtrusive and problematic for those who work with them in the day care center.

- Day Treatment: Day programs for children and youth with SED are designed to reduce psychiatric symptoms and improve the client's level of functioning. Programs are designed for clients needing less than hospitalization but more than intermittent outpatient services.

- Project BASIC (Better Attitudes and Skills in Children): An elementary school-based mental health early intervention and prevention program that works with children from kindergarten through third grade. Goals are to enhance awareness and capacity for response of school personnel to the mental health needs of children and to reduce the incidence of adolescent and adult mental health problems. Children with SED are identified and referred for mental health services.

➢ **Rehabilitation Services**

- There are no targeted rehabilitation services for children and youth. However, rehabilitative activities occur within a number of day treatment, respite, educational, residential, and transitional program activities.

➢ **Employment Services**

- The Department of Education (DOE) requires transition plans to be included in the Individual Education Plans (IEP) of all children in special education who are fourteen years or older, some of whom are assessed as SED. This includes the assessment of vocational alternatives.

- The Division of Rehabilitation Services provides transition-from-school-to-work case managers in the schools or Rehabilitation Counselors who work with a school.

➢ **Housing Services**

- Intensive Residential Care: A highly structured, staff secure, community-based, twenty-four hour residential treatment for a specialized sub-population of children and youth with serious emotional disturbance.
- DCS foster care program
- Permanent Housing site for homeless women with children

➢ **Medical and Dental Services**

- Primary Care Physician and Specialist Medical Services under TennCare
- EPSDT assessment for all enrolled children under twenty-one is provided through TennCare.
- Medical and dental services are provided as medically necessary for children and youth who are eligible for TennCare.

➢ **Educational Services**

- Educational Day Treatment: Day treatment services are funded for children and youth with SED through the TCPP. DMHDD has recommended school-based day treatment to be the preferred model for delivering this service. Non-school-based day treatment programs, which provide education as a component of the program, must qualify as approved schools per DOE policies and procedures.

- PL 105-17: Individuals with Disability Education Act (IDEA): Part C is administered by the DOE. Services and activities developed under Tennessee's Part C process include: an 800 telephone number information and referral line, a directory of services available in each area of the state, child-find activities, community awareness activities, and contracted mental health case management services. All children included in Part C have an Individualized Family Service Plan (IFSP) and appropriate services provided. An Interagency Coordinating Council meets regularly to guide these activities and to develop and monitor the State's Plan for Part C. Disabilities, which can be served under Part C, include social and emotional delay.

➢ **Substance Abuse Services**

- Primary alcohol and drug prevention, education, and treatment services are provided through contract agencies of both the BHOs and the DOH, Bureau of Alcohol and Drug Abuse Services.

➢ **Case Management Services**

- Mental Health Case Management Services must be offered to children and youth assessed as SED and are available to others as medically necessary.

➢ Services for Special Populations

- Services for Children and Youth with Co-occurring Disorders (COD): Children with co-occurring disorders have access to the range of services offered by TennCare and the BADAS. The TCPP has pursued the development of intensive outpatient services for adolescents with co-occurring disorders in targeted deficit areas. Funding allocations in FY04 include four specialized programs to serve youth with Substance Abuse and COD in thirty-one counties across Tennessee.

- Services for Children and Youth with Dual Diagnosis (MR/DD and MH): Funding allocations in FY04 include three projects to provide therapeutic foster care, case management, and intensive in-home treatment and support services for dually diagnosed children and youth.

- Services for Children and Youth in the Juvenile Justice System: Forensic evaluation and treatment services are provided for youth under Juvenile Court Order. Funding allocations in FY04 include juvenile sex offender assessment and treatment programs in six locations across Tennessee.

- Services for Homeless Populations: DMHDD funds an outreach case management program in six locations statewide for families who are homeless and have children. Staff identify children and youth with or at risk of SED and provide referral as appropriate. One permanent housing location serves only women with children.

- Services for Children of Parents with SPMI: This is a pilot program to provide education and support for children and youth who have a parent diagnosed with a mental illness with a school-based outreach curriculum, Mental Health 101.

➢ Other Support Services

- Family Support and Advocacy: Tennessee Voices for Children (TVC), the Tennessee affiliate of the Federation of Families for Children's Mental Health, manages a family support group network across the state for families of children with SED, with family groups in each of the three grand regions of the state. TVC provides technical assistance and consultation for the development of these groups, distributes printed materials, refers families to services, and performs parent advocacy and training activities through family outreach specialists.

- Family Resource Centers: Some104 Family Resource Centers are located at or near school buildings in communities across the state. Resource centers coordinate state and community services to help meet the needs of families with children.

- Planned Respite Services: This is a model program that provides respite services to families of children identified with SED, or dually diagnosed with SED and mental retardation, who are ages two to fifteen. Respite consultants provide short-term respite and work with the family to identify long-range respite resources. Individualized family respite plans are

developed with the family. The consultant enables families to develop community-based respite resources and utilize them effectively.

The newly chartered Tennessee Respite Coalition is promoting "across the lifespan" respite services through support of the Lifespan Respite Care Act of 2003 and will be piloting a respite voucher program for families of children with SED and developmental disabilities in Shelby County in FY04.

- Parent/Professional Support Groups: These support groups are co-lead by both a parent of a child with SED and a professional. The member families determine the agenda and hire their own professional co-facilitator.

- Erase the Stigma Project: Contracted through the Mental Health Association, these funds support a statewide anti-stigma program for children and youth through mental health presentations both in schools and in the community. Events, project goals, and presentations are developed in collaboration with major children's advocacy groups.

- Statewide suicide prevention hotline, support groups, and staff training in suicide prevention.

Monitoring of Contract Services

(Please see description of monitoring activities in Adult Criterion 1 on page 46.)

Access and Eligibility Issues: Mental Health Managed Care System

(Please see description of access and eligibility issues in Adult Criterion 1 on page 46.)

➢ TennCare Access

Persons may apply for TennCare eligibility at their local DHS office at any time; however, if not Medicaid eligible, enrollment in TCS has certain limitations. To be eligible for TCS as "uninsured", TennCare enrollment must be open. To be eligible for TCS as "medically eligible", the following criteria must be met:

1. Current assessment as SED
2. Qualifying medical diagnosis
3. Health insurance denial option (uninsurable)
4. Income no greater than 100% of poverty

Medically necessary behavioral health services may also be provided under a state-only designation. Children and youth defined as SED (see C&Y Criterion 2 on pages 88-89) who meet the poverty guidelines may be enrolled for coverage of needed behavioral health services. State-only eligibility assessments are completed at state mental health institutes and community mental health agencies. State-only status ends when the enrollee becomes eligible for TennCare or other insurance.

➢ Key Services

A second door of access lies within the availability and comprehensiveness of the benefit package. Currently, the TCPP offers a generous benefits package including mental health services that increase access to care.

- Mental Health Case Management: Case managers serve as the agent for linking priority population children and their families to mental health, primary health care, and other needed services. Services consist of the following components: assessments and prioritization of needs; service plan development; linking the child and his/her family or caregiver with necessary community resources and support groups; assistance in daily living; referral to other community services; advocacy; crisis response; and monitoring the overall service delivery plan.

  Case managers endeavor to empower families to be able to take care of their child and provide a conducive environment for the family to function, grow, and direct their own interventions; using the community as the number one resource. Services can vary in intensity and duration, depending on assessed need; but go beyond a gatekeeping function with the major goals of parental empowerment and family stabilization, leading to improved quality of life for the child and his or her family.

- Specialized Crisis Services: Following a study of the unique dynamics of crisis service delivery to children and adolescents, a separate statewide contract was negotiated to provide specialized crisis services to children and youth. Beginning in June 2003, the service reports a 79% diversion rate with a three-hour average time spent on face-to-face contact.

- Symptom Management: Needed outpatient services may be provided in the community in the individual's natural environment; i.e., home, school. The TCPP covers this service.

- EPSDT: A mandated Medicaid program and a key component in the program's provision of care to children. Medically necessary services as assessed by EPSDT screening must be provided by the TennCare Program to enrollees under twenty-one years of age.

Consumer Information/Ombudsman Service

(Please see information in Adult Criterion 1 on page 48.)

Utilization Management Protocol and Due Process Protections

(Please see information in Adult Criterion 1 on page 48.)

Inpatient Utilization

The BHO contracts with sixteen inpatient psychiatric hospitals to provide inpatient care for children and youth. Three of these contracted facilities are state RMHIs: Lakeshore Mental Health Institute (LMHI) in Knoxville, Middle Tennessee Mental Health Institute (MTMHI) in Nashville, and Western Mental Health Institute (WMHI) in Bolivar. DMHDD operates five RMHIs; however, Moccasin Bend Mental Health Institute (MBMHI) in Chattanooga and Memphis Mental Health Institute (MMHI) in Memphis do not operate C&Y programs.

➢ State Regional Mental Health Institutes

The three RMHIs serving children reported 1,236 youth under 18 received 1,455 admissions during FY03; an average increase of 3% over FY02. LMHI is the only RMHI with a decrease. Of these 1,236 admissions, approximately 60% listed the BHO as the guarantor of payment, but the number of SED is not reported. (Of the total TennCare enrollees under eighteen with SED receiving inpatient psychiatric services during FY02, 26% were served in the three state institutes serving children.)

➢ Other Psychiatric Inpatient Providers

During FY02, approximately 74% of TennCare enrollees under eighteen receiving inpatient psychiatric services were hospitalized at private community treatment resources.

Activities to Reduce Hospitalizations

➢ Inpatient Utilization Review

DMHDD staff closely monitor utilization of the state-operated RMHI beds, tracking trends in admissions, average daily census, length of stay, and readmission rates as compared with the same time period in prior fiscal years.

Overall TCPP inpatient utilization is monitored by the BHO and quarterly reports are prepared and reviewed by DMHDD and the TCPR. Reports include utilization rates per thousand for adults and youth psychiatric and substance abuse inpatient services. Reports are used by the Department, inpatient facilities, and regional stakeholders to monitor the effectiveness of inpatient care, the continuity of service planning, and the adequacy of community services.

For those for whom hospitalization is the most appropriate option, length of stay is impacted by early discharge planning and the timely availability of less restrictive alternatives. Needs for treatment, housing, case management, support groups, and consumer and family education services must be adequately identified and addressed prior to discharge from inpatient care.

➢ Less Restrictive Alternatives to Hospitalization

- To assist in the transition of children and youth in state custody from acute hospital-level care to community-based residential or outpatient programs, DMHDD, via contracts with DCS, provides sub-acute care options at the three RMHIs serving children and youth. DMHDD also participates with DCS and the Tennessee Commission on Children and Youth (TCCY) regarding the mental health needs of children and youth who are in state custody and in DCS-operated facilities in order to encourage utilization of least restrictive alternatives.

- The specialized contract for crisis services is expected to have a positive effect on the inpatient utilization rates of children and youth. One goal of the program is to decrease the use of hospital emergency rooms by families or other caregivers as the first point of contact in a crisis situation. Current data indicates a higher percentage of diversion for those seen in their current living environment as compared to those initially seen in an emergency room.

- Prevention and early intervention services for children can avert the development of the most serious symptoms of emotional disturbance or mental illness. Early intervention with children has a far greater long-term potential to reduce the need for psychiatric hospitalization.

Reduction in the rate of hospitalization is impacted by services such as case management, respite, family education, crisis response, and the availability of less restrictive alternatives. DMHDD supports, through its contracts, services targeted toward early intervention and prevention for children and youth and education, respite, and support for families.

Legislative Initiatives

DMHDD worked with legislators and law enforcement officials to amend statutes to allow family members, clergy, mental health professionals, and others to transport individuals for emergency hospitalization who do not require security. These are primarily people who are unable to care for themselves or keep themselves safe because of their mental illness.

A major problem area was also addressed in legislative change this year. The Department has been exploring ways to address a shortage of nursing. Legislation was successfully passed to alter the state's personnel practices to provide more flexibility in recruitment, scheduling, and retention of nurses. This will support more full time nurse positions and reduce dependence on contract agency nurses. These changes are expected to improve nursing care in the state hospitals.

PERFORMANCE INDICATOR DESCRIPTIONS

Goal 1: **To maximize the ability to remain in a community setting by providing coordinated service delivery in the most appropriate, least restrictive environment available.**

Objective: To maintain the number of admissions to psychiatric acute care facilities at a maximum of 10%.

Population: TennCare enrolled children and youth assessed as SED and receiving TennCare Partners services during FY04.

Criterion: **Comprehensive, Community-Based System of Care**

Brief Name: **C&Y Admissions**

Indicator: Number of admissions to acute inpatient care by children and youth in the priority population who are receiving services.

Measure: % Numerator: Unduplicated # of children and youth with SED admitted to inpatient psychiatric acute care

Denominator: Unduplicated # of children and youth with SED receiving a TennCare Partners service

Sources of Information: DMHDD, Office of Managed Care, Research & Analysis Group

Special Issues: An acute care admission is defined as one that results in a hospital stay of less than thirty (30) days.

Significance: A major outcome of a comprehensive, community-based mental health system of care is the reduction of the need for inpatient hospitalization.

Goal 2: **To offer effective inpatient treatment and continuity of care to enable the service recipient to remain in a community setting.**

Objective: To reduce the number of readmissions to inpatient care within 30 days.

Population: Children and youth assessed as SED receiving a TennCare Partners acute psychiatric inpatient service during FY04.

Criterion: **Comprehensive, Community-Based System of Care**

Brief Name: **I/P Readmission**

Indicator: Percentage of C&Y with SED receiving TennCare services who are readmitted to acute inpatient care within 30 days.
acute inpatient care.

Measure: % Numerator: Unduplicated # of C&Y with SED readmitted within 30 days of discharge.

Denominator: Unduplicated # of C&Y with SED admitted to inpatient psychiatric acute care

Sources of

Information: DMHDD, Office of Managed Care, Research & Analysis Group

Special Issues: Readmission is defined as admission to any inpatient psychiatric hospital within 30 days of discharge from inpatient stay.

Significance: A major outcome of a comprehensive, community-based mental health system of care is the effectiveness of inpatient treatment and the continuity of community care.

Goal 3: To provide case management services to individuals with SED receiving benefits under TennCare. .

Objective: To expand case management services to children and youth with SED by 2%.

Population: TennCare enrolled children and youth with TPG assessment of 2 receiving a TennCare Partners service during FY04.

Criterion: Comprehensive, Community-Based System of Care

Brief Name: C&Y CM

Indicator: Percentage of children and youth in the priority population who receive a mental health case management service

Measure: % Numerator: Unduplicated # of children with SED receiving a mental health case management service

Denominator: Unduplicated # of children with SED receiving a TennCare Partners service

Sources of Information: DMHDD, Office of Managed Care, Research & Analysis Group

Special Issues: Enrollment of children and youth under the age of eighteen is dependent upon parental or guardian acceptance of the service on behalf of the child.

Significance: Assuring access to case management services for children and youth with SED is a primary goal of community-based services and a commitment of DMHDD and TennCare.

FY04 STATE MENTAL HEALTH PLAN PERFORMANCE INDICATOR
SED C&Y DATA TABLE

Criterion: 1. Comprehensive Community-Based Mental Health System

	SFY02 Actual	**SFY03** Projected	**SFY04** Objective	**%** Attain
Performance Measures:				
1. I/P Admissions*				
Value:	8.6%	N/A	10% (or less)	_____
IF Rate:				
Numerator	2,237	N/A		_____
and				
Denominator	25,849	N/A		_____
Performance Measures:				
2. I/P Readmission*				
Value:	N/A	N/A	20% (or less)	_____
IF Rate:				
Numerator		N/A		_____
and				
Denominator		N/A		_____
Performance Measures:				
3. C&Y CM*				
Value:	51%	N/A	↑ 2%	____
IF Rate:				
Numerator	13,249	N/A		____
and				
Denominator	25,849	N/A		____

* TennCare claims data processing may lag by several months; therefore, a full 12-months of data may not be included in total numbers.

Criterion 2
Mental Health System Data Epidemiology

Estimate of Prevalence of SED

The Federal Register of July 17, 1998 (Volume 63, Number 137) gives states an SED prevalence estimate range of 5-13% for children and youth ages 9-17 years, depending on poverty rates and level of functioning scores. To keep a comparable demographic age range between census data and the state reporting system, Tennessee estimates SED prevalence for children and youth ages 0-17 years.

Based on a higher than average level of poverty in some counties and a stringent assessment criteria, DMHDD has traditionally used the higher rate of the lower level of functioning group, or 9% of children under 18 (125,961), to estimate the total number of children and adolescents with SED residing in Tennessee. This results in an estimate that is 32% higher than the highest estimate in the Federal Register (85,614) and 26% higher than the highest estimates based on the 2000 US Census figures for ages 9-17 (92,378).

Given the above information, Tennessee will now utilize the lower 7% of the under 18 population to more closely approximate the federal estimate of prevalence of SED. The number of these youth that could be expected to access the public mental health system is unknown.

Table 2.01 below shows estimates based on the above criteria as well as the TennCare enrollment of that population during FY03.

TABLE 2.01 ESTIMATED # OF PRIORITY POPULATION & TENNCARE ENROLLMENT

2000 Census TN population (Under 18)	Estimated % SED	Total	SED TennCare Enrolled (FY03)*	Penetration Rate for FY03
1,399,564	7%	97,969	65,552	67%

** Individuals with a TPG assessment code 2 (SED) enrolled in TennCare for any period of time during July 2002 through June 2003. Source: Research & Analysis, Office of Managed Care, DMHDD, August 2003.*

Priority Population Determination for Individuals Under Eighteen

Children and adolescent priority population definition: Children and adolescents from birth up to age eighteen years who currently have, or at any time during the past year have had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Since 1994, Tennessee has used the Targeted Population Group (TPG) form to classify the children and youth priority population for mental health service delivery. A Global Assessment of Functioning (GAF) measurement of 50 or below (current or lowest in last six months) is used to determine functional impairment.

Community Mental Health Agency (CMHA) and state RMHI staff receive training in completing the TPG assessment. A "Train the Trainer" model is utilized and designated individuals are responsible for providing training to other agency staff. The BHO conducts training and maintains a current listing of staff certified to conduct priority population assessments.

Staff use the TPG as a tool to record the following:

- diagnosis(es),
- a global assessment of functioning (GAF) measurement, and
- determination of whether the youth has SED or is at risk of having SED (based on the federal definition).

Children and adolescents are classified into one of three groups.

TPG 2: Children with SED: Tennessee currently uses the federal definition for children and adolescents with SED as its priority population definition.

TPG 3: Children at Risk of SED: These are children who, because of particular environment or family circumstances or other risk indicators, are at risk of becoming SED. They do not have a current, valid psychiatric diagnosis and/or are not functionally impaired. With early detection, prevention, and treatment, the severity of future problems can be reduced substantially.

TPG 4: Children who do not meet the criteria of TPG 2 or 3: These children and adolescents do not have a current, valid psychiatric diagnosis, or are not functionally impaired and are not at risk of SED.

(Historically, TPG 1 was used to classify children and youth in state custody, but this category is no longer used.)

The under-eighteen priority population is identified as those assessed as TPG 2, children and adolescents with SED. These youth and their families require continued or specialized mental health and substance abuse treatment services to improve the child's functioning level. Services may include education and support services to increase understanding in the child's environment and to maintain family integrity.

Eligibility for Behavioral Health Benefits

The basic and enhanced benefits packages were collapsed into a single benefit package on April 1, 2003. Access to all TennCare Partners covered services is based on the medically necessary criteria as defined in Adult Criterion 1 on page 42. Currently, TennCare eligible children and youth under age twenty-one may access any medically necessary service through EPSDT screening.

Quantitative Targets to be Served

- TennCare

Under the TCPP, the CMHAS, RMHIs and other providers have entered into contractual agreements with the BHO to provide mental health services. Based on encounter data processed to date, 27,162 children and youth assessed with SED received a TennCare Partners service during FY03.

- DMHDD Contract Services

The network of agencies with which the Department contracts to provide mental health services for children and youth includes fourteen CMHCs and seven other community organizations

Quantitative targets in each service program funded through the CMHS Block Grant and other state funds not designated to the TCPP are summarized in Table 2.02 on page 91. Noting that a projection of numbers to be served is not applicable to all services, it is estimated that over 144,000 children and 2,000 family members, teachers, and other adults will benefit from DMHDD contract services during FY04.

TABLE 2.02 PROJECTED NUMBER TO BE SERVED THROUGH FY04 FUNDING (BOTH CMHS BLOCK GRANT AND STATE FUNDS)

Children and Youth Service Category	Estimated Number To Be Served *
Project BASIC	13,500 children
Family Support Groups	200 individuals
Planned Respite	280 children
Regional Intervention Program (RIP)	550 children
Homeless Outreach	400 families 800 children
Education & Training Project - "Erase the Stigma"	50,000 children, families, others
NAMI Parent Education - "Visions for Tomorrow"	50 caregivers
Pediatric Liaison Services	Not Established
Education of Children & Youth of Parents with SPMI	Not Established
Suicide Prevention Plan	Not Established
Jason Foundation Curriculum	Not Established
Early Childhood Network	Not established
Early Childhood Intervention (Day Care Consultation)	Not established
Primary Care Interface	Not Established

***** All contracts describe a scope of services, but may not require a projection of number to be served.

PERFORMANCE INDICATOR DESCRIPTIONS

Goal 1: **To maximize access to healthcare coverage for children and youth in Tennessee, including the portion meeting criteria for SED.**

Objective: To maintain 50% enrollment of the annual estimated prevalence of children with SED at some period of time during FY04.

Population: Children and youth in priority population, TennCare eligible.

Criterion: **2: Mental Health System Data Epidemiology**

Brief Name: **C&Y Enrolled**

Indicator: Percent of youth in the estimated priority population that are TennCare enrolled.

Measure: % Numerator: The number of SED children and youth enrolled in the TennCare Partners Program
Denominator: Estimated prevalence of SED in Tennessee

Sources of Information: DMHDD, Office of Managed Care, Research & Analysis Group

Special Issues: With a 15% population growth in children and youth under the age of eighteen, enrolling eligible individuals into TennCare will assist in providing health insurance coverage to all Tennesseans, including those with SED.

Significance: The impact of the TennCare waiver changes will not be known immediately. Until impact data is available, maintenance of FY02 enrollment will be the goal.

Goal 2: **To ensure that TennCare enrollees with SED and their families have access to community mental health services.**

Objective: To maintain service access to at least 90% of TennCare child and adolescent enrollees with a current priority population assessment.

Population: Children and youth, TennCare enrolled with a current TPG 2 assessment.

Criterion: **2: Mental Health System Data Epidemiology**

Brief Name: **C&Y Served**

Indicator: Percent of youth in the priority population that are TennCare enrolled and receiving behavioral health care services during FY04.

Measure: % Numerator: The number of SED children receiving a TennCare Partners service
Denominator: Number of SED enrolled in TennCare Partners

Sources of Information: DMHDD, Office of Managed Care, Research & Analysis Group

Special Issues: A current TPG assessment is defined as an assessment of TPG 2 within one year.

Significance: Individuals with health care benefits can only benefit by ease of access, non-discrimination, provider availability, and education regarding resources.

FY04 STATE PLAN IMPLEMENTATION REPORT PERFORMANCE INDICATOR C&Y SED DATA TABLE

Criterion: 2: Mental Health System Data Epidemiology

	FY 02* Actual	**SFY03** Projected	**SFY04** Objective	**%** Attain
Performance Indicator: 1. **C&Y Enrolled**				
Value:	59.9%	N/A	50%	____
IF Rate: Numerator and Denominator	58,668 / 97,969 ❶	N/A		____

❶ Number based on projection of 7% of under-eighteen population using 2000 census figures.

Performance Indicator: 2. **C&Y Served**				
Value:	93.6%	N/A	90%	____
IF Rate: Numerator and Denominator	25,849 / 27,607❷	N/A		____

❷ Unduplicated number of children and youth enrolled in TennCare during FY02 with a current (within one year) assessment of TPG 2 (SED).

* TennCare claims data processing may lag by several months; therefore, a full 12-months of data may not be included in total numbers.

Criterion 3
Children's Services

Child Service System

The system of mental health care for children and youth, including children and youth with SED, consists of four service delivery entities: TennCare/TennCare Partners; DCS for children in or at risk of state custody; DMHDD-contracted services and state hospitals; and the DOH, Bureau of Alcohol and Drug Abuse Services.

- The Bureau of TennCare contracts with MCOs and DMHDD contracts with BHOs to deliver medically necessary physical care, mental health care, and substance abuse services, including EPSDT assessments for TennCare eligible children and youth to age twenty-one. The MOU between the Bureau of TennCare and DMHDD serves to further the integration of policy and program development for children and youth receiving services under the TCPP.

- DCS was created by joint effort of the General Assembly and the Governor's Office in July 1996 to fulfill the state's responsibilities for children committed to, or at risk of commitment to, the state's custody. These custodial duties were previously distributed across the Departments of Mental Health and Mental Retardation, Human Services, Youth Development, and Education. DCS provides for children who are placed in state custody, or are at risk of placement in state custody.

  DCS provides an array of services to children and youth in legal and physical state custody. Many of these children enter custody due to neglect, abuse, abandonment, delinquency, or are awaiting adoption. As of March 11, 2003, 9,748 children were in state custody. Almost all custodial children and youth are enrolled in TennCare. The TCPP provides for medically necessary services with the exception of residential treatment services, which are the responsibility of DCS. Mental Health case management services for children in state custody with SED can be accessed through the TCPP.

- DMHDD, through Block Grant funding and state appropriations, contracts with multiple agencies to deliver education, prevention, early intervention, respite, and outreach mental health services for children and youth with or at risk of SED.

  DMHDD manages three children and youth inpatient psychiatric programs that provide acute and extended care in the RMHIs at Knoxville (LMHI), Nashville (MTMHI), and Bolivar (WMHI) and contracts for outpatient and inpatient mental health evaluations of children and youth ordered by juvenile courts.

- The Bureau of Alcohol and Drug Abuse Services provides for education, early intervention, and non-TennCare-covered substance abuse treatment services for children and youth through state funding and the Substance Abuse Block Grant.

Integration of Services

Tennessee's integrated statewide system of services for children and youth with SED includes social, education, juvenile justice, substance abuse, and mental health. The service integration is accomplished via multiple linkages and interactions between the four primary departments of state government that serve youth and their respective networks of provider agencies. The Departments of Health, Education, Children's Services and Mental Health and Developmental Disabilities each have complementary responsibilities for meeting the needs of children and youth.

- Social Services: DMHDD provides consultation to DHS staff on mental health treatment issues, community resources, and referral procedures to utilize in the training of case managers who will work with special needs families participating in Tennessee's welfare to work program, Families First.

- Educational Services: The DOE approves the special education annual plans of all schools operated by DMHDD and DCS. Staff from each department participates in common projects (e.g. Dropout prevention, Family Resource Centers). In addition, DMHDD has an extensive presence in school systems with the Jason Foundation curriculum and, particularly, in rural areas with Project BASIC. (See service descriptions in C&Y Criterion 5 on page 109.)

- IDEA Services: The DOE has the lead responsibility for implementing the IDEA. Special education and related services for children and youth with SED are specified in an IEP and provided by the local education agencies, the DCS contract provider or facility school for children in state custody, or schools operated by DMHDD for children and youth in RMHIs. An interagency agreement defines the fiscal responsibilities for special education related services between DOE and the Bureau of TennCare.

- Juvenile Services: DMHDD contracts for court-ordered evaluations and mental health services for children and youth committed by the juvenile court. Both inpatient and outpatient evaluation services are provided. DMHDD Forensic Services staff monitor all evaluations and assist in accessing recommended treatment services as necessary.

- Substance Abuse Services: The Bureau of Alcohol and Substance Abuse Services provides a number of prevention programs for children, including intensive focus groups, the Tennessee Teen Institute, and The Faith Initiative targeting pre-adolescent children living in single parent households in inner-city housing developments.

  Bureau-funded treatment services are primarily targeted to persons with no other means of paying for treatment. Funding also targets special needs populations such as pregnant women, women with dependent children, adolescents, and persons of any age at risk for or infected with HIV.

DMHDD ensures the integration and coordination of mental health services into a meaningful system via ongoing participation with other child serving departments as well as providers, consumers, families, and advocacy organizations represented in the SMHPC and RMHPCs. Through the above identified mechanisms, DMHDD continues to participate in Tennessee's integrated system of services for children and youth.

The program descriptions below further document integrated service efforts.

- **The Nashville Connection**

Tennessee was awarded a five year System of Care grant to develop a model for the state. The State System of Care Council, comprised of managers from child serving departments, parents of children with SED and advocates, meets quarterly to address state level policy issues related to the development of a System of Care.

Critical areas identified for interagency attention include funding coordination, family involvement, cultural competence, creative problem solving, public awareness, effective interagency agreements, and coordinated cross training of professionals. A Youth Council, comprised of youth with SED and siblings of youth with SED, conducts a number of educational and advocacy activities.

The Nashville Connection participates with other agencies and community coalitions to identify system of care issues and solutions.

- **Early Childhood Network**

This is a collaborative effort on the local level to identify and address the mental health needs of preschool through third grade children through prevention and early intervention strategies. Community partners will identify gaps in services and collaborate with available resources to determine what each partner can contribute toward meeting these needs.

The effort is intended to provide a seamless and comprehensive system to identify and serve, at an early age, children in need of mental health services by networking all local agencies that work with this age group.

Funding supports projects in two counties that currently have DMHDD funded RIP, BASIC, and Day Care Consultation services. (See C&Y Criterion 1 on page 78.)

- **Jason Foundation School Curriculum**

In response to the Surgeon General's Call to Action to Prevent Suicide Plan, Tennessee developed fifteen strategies. One of the strategies specifically targets providing educational programs for youth that address suicide. The Jason Foundation offers a Triangle of Prevention approach for awareness and prevention of youth suicide.

The Triangle of Prevention consists of programs that address youth, parents, and teachers/educators in suicide awareness and prevention through educational programs and seminars. The goal is to place this program in all middle and high schools in the state of Tennessee over the next three years.

- **BASIC**

Project BASIC is an elementary school-based mental health early intervention and prevention service that works with children from kindergarten through third grade. Each of the BASIC project sites is in collaboration with a city or county school system, including teachers, principals and superintendents of schools.

In addition, DMHDD hosts pass-through federal Byrne grant funding for a local CMHA to support PEER (prevention education enhances resiliency) Power. Staff provide training for classroom teachers and direct services to students in grades 4-8 in middle Tennessee to instill resiliency in children in order to prevent violent behaviors.

Transition Services

While no formal transitional program exists, Tennessee has taken steps to assure the smooth transition from children and youth services to adult services.

- As per the Chaffee Act, DCS has developed a state plan for transition services for children and youth leaving state custody at any age. The plan requires that funding for necessary services be available through that program.
- The BHO contract requires an ensured coordination between the child and adolescent service system and the adult service system.
- Under recent mental health law revision, TCA 33-8-105 requires providers to develop interagency transition plans for all seventeen year olds in state custody who need to continue into adult services.
- DOE requires transition plans to be included in the IEPs of all children in special education who are fourteen years or older. This includes those who are assessed as SED.

Children's Cabinet

By Executive Order, the Governor's Children's Cabinet was established in March 2003 and is charged with coordinating and streamlining the state's efforts to provide needed services to Tennessee's children. It is expected to focus on a broad range of issues and challenges, including but not limited to fighting abuse and neglect, promoting foster care and adoption, and raising public awareness of children's issues.

The Commissioners of the DCS, DOE, DOH, DHS, DMHDD, the Executive Director of the TCCY, and six citizens who have demonstrated a strong commitment to and understanding of the challenges and issues affecting Tennessee's children serve as members of the Children's Cabinet.

PERFORMANCE INDICATOR DESCRIPTIONS

Goal 1: **To enhance service access for children and youth with a mental health diagnosis who are substance abusers or at risk of substance abuse.**

Objective: To increase the number of children and youth with a mental health diagnosis or SED who are receiving substance abuse services by 2%.

Population: Children and youth with SED or a mental health diagnosis enrolled in TennCare.

Criterion: **3: Children's Services**

Brief Name: **C&Y SA**

Indicator: Number of children who receive a substance abuse service through the Substance Abuse Block Grant or TCPP services.

Sources of Information: Bureau of Alcohol & Drug Abuse Services Data, BHO report

Special Issues: For the Bureau of Alcohol & Drug Abuse Services data, the field will be limited to those under eighteen with a mental health diagnosis who receive a service under the Substance Abuse Block Grant.

For BHO data, the field is limited to children with SED with a co-occurring substance use diagnosis. Efforts are underway to identify separate mental health and substance abuse TennCare Partners encounter data for future reporting purposes.

Significance: Assuring access to services for children and youth with a mental health diagnosis and a co-occurring substance use disorder.

FY04 STATE MENTAL HEALTH PLAN PERFORMANCE INDICATOR
C&Y SED DATA TABLE

Criterion: **3: Children's Services**

	FY02 Actual	**FY03** Projected	**FY04** Objective	**%** Attain
Performance Indicators:				
1. **C&Y SA***				
Value:	842**	N/A	↑2%	

* TennCare claims data processing may lag by several months; therefore, a full 12-months of data may not be included in total numbers.

****** Combined number of children and youth with SED and a co-occurring substance use diagnosis served by TCPP and number of children and youth with a mental health diagnosis served under the Substance Abuse Block Grant.

Criterion 4
Targeted Services to Rural and Homeless Populations

Description of the Homeless Populations in Tennessee

In Tennessee, individuals with mental illness who are homeless are defined as those who meet the definition for the priority population and who also lack a permanent residence. A permanent residence is defined as a place of one's own where one can both sleep and receive mail. National studies suggest that one-third to one-half of homeless individuals suffer from mental illness.

DHS has estimated that 25% of homeless persons are families with children. More recent studies (2002) by the National Coalition for the Homeless indicate that the number of homeless families is on the rise and estimates the number of families with children as closer to 39%. The DOE, under the auspices of the McKinney Homeless Assistance Act, served over 4,000 homeless children in the school system during FY02 and expect an increase when FY03 numbers are submitted. The C&Y Homeless Outreach Program served 18% more children in FY03 than during FY02.

Various surveys have estimated the number of adult homeless persons in Tennessee as between 17,000 and 18,000. Using the estimate that 25% of homeless persons are families with children, we can estimate some 4,250 to 4,500 homeless families with children in Tennessee.

Outreach and Services to Children and Youth who are Homeless

Homeless parents may access TennCare for their children through Medicaid eligibility or TennCare Standard. Children who are eligible for TennCare Medicaid have access to a range of mental health services as determined by medical necessity through EPSDT. Parents may use agency addresses, shelter addresses, or a Post Office Box as an address for TennCare.

Homeless children and families who are not TennCare eligible have access to crisis response and intervention services statewide and may participate in no-cost family support groups and school-based prevention programs at various locations throughout the state. Over 300 organizations statewide describe themselves as providing a service to some segment of the homeless population. However, only a small number of these have as their primary purpose the provision of services to homeless individuals with mental illness and even fewer to families with children.

The DCS, while not collecting data specific to "homelessness", identifies and serves homeless children and their families as part of the dependent and neglected population, providing a wide variety of services through DCS, TennCare, TCPP and other state departments such as DHS.

DMHDD's Independent Living Assistance for initial and on-going rent or utility bill payment is available for priority population homeless adults who receive agency services and wish to seek and maintain housing for their families.

- Homeless Outreach for Children & Youth

Outreach case management services for homeless children and youth with SED, or at risk of SED, are funded in the Nashville/Davidson County area, the Johnson City area, and in the cities of Chattanooga, Knoxville, Jackson, and Memphis.

Homeless Outreach staff assist homeless families in identifying children and youth with SED or who may be at risk of SED. Staff assist the parent(s) in securing needed mental health services for their children and link them with other services needed to keep the family intact and healthy. Outreach staff also refer children for EPSDT screening, which often is the first contact with medical services since birth.

The homeless outreach worker functions as a liaison between the school and the family when special education services are needed, facilitates mental health evaluation and treatment, and assists the family in securing more permanent housing.

Staff provide assistance until the family becomes linked with more durable, on-going case management, treatment, and social service agencies, is no longer homeless, or no longer accepts services.

DMHS funds each of the six programs with flexible funding. These funds are used to purchase a variety of goods and services that are not otherwise funded such as emergency housing, respite, therapeutic summer camp, clothes, school supplies, transportation, and emergency child care.

- Permanent Housing

There are three housing programs funded through the federal McKinney Act Permanent Housing for Homeless Program. The Knoxville site has sixteen apartments dedicated for women with serious mental illness and their children.

The Office of Housing Planning and Development (OHPD) through the Creating Homes Initiative has worked in collaboration with local community groups, both urban and rural, to expand housing options for homeless persons with mental illness.

Definition of Rural

The U.S. Census Bureau's definition language for rural is "all territory, population, and housing units located outside of urbanized areas and urban clusters". There is no current statistical table to identify "rural" Tennessee counties under this new definition. In Tennessee Statistical Abstract, 1994-95, a county is identified as "rural" if it is 50% or more composed of unincorporated cities of 2,500 or less. The 1990 Census reports seventy-seven of ninety-five Tennessee counties meet the definition of rural. These seventy-seven counties all have fewer than 1,000 persons per square mile.

Services to Rural Populations

➢ TCPP

The TCPP policies require equal eligibility, service coverage, and availability statewide to both urban and rural Tennessee residents. TCPP provides a comprehensive continuum of services ranging from acute inpatient care to case management for eligible populations.

A critical issue for rural residents is their ability to access available services, especially medical health specialists. In the mental health arena, several rural-based CMHAs participate in the federal rural recruitment and retention plan to hire psychiatrists and psychologists, particularly those with expertise in child psychiatry or psychology.

➢ DMHDD

Tennessee augments traditional clinical services with alternative services designed to decrease discrimination, engage rural families, and provide opportunities for education and support in areas where there are few community resources.

- The great majority of C&Y Project BASIC sites are in poor, rural areas of the state and are a partnership between a local school and the local CMHC.

- DMHDD involves individuals from rural Tennessee in the planning process and has ensured that there is representation from families, consumers, providers and other advocates from rural areas on the SMHPC, RMHPCs, and the DPPC. The Department provides travel reimbursement to consumers and family members in an effort to encourage participation at all Council business meetings.

- The Department's Family Support & Advocacy Program, implemented by TVC, operates statewide and has successfully provided community education in rural areas of the state, based on needs assessment surveys of the community.

- The Mental Health Association of Middle Tennessee, in conjunction with Tennessee Rotary Clubs, sponsors "Erase the Stigma" presentations statewide to school, civic, and community groups. Fifty percent (50%) of presentations are required to be in rural counties.

PERFORMANCE INDICATOR DESCRIPTIONS

Goal 1: **To provide outreach to homeless families in Tennessee to promote assessment and service access, especially for children with SED or at risk of SED.**

Objective: To increase number of children who receive a mental health assessment by 2%.

Population: Children suspected of SED, or being at risk of SED, who are in homeless families.

Criterion: **4: Targeted Services to Homeless and Rural Populations**

Brief Name: **C&Y Referral**

Indicator: Percentage of children who access mental health services after a referral by the Outreach Team.

Measure: % Numerator: Unduplicated # of children accessing services.
Denominator: Unduplicated # of children referred for services.

Sources of Information: C&Y Homeless Outreach Project Annual Report

Special Issues: While assessment and service access are available for homeless families with children with SED, or at risk of SED, follow-up with referral is dependent on follow-through and system capacity.

Significance: Children of homeless families are at increased risk of experiencing physical neglect and/or developing behavioral and/or emotional problems or substance abuse.

Goal 2: **To provide referral for services for homeless families with children in Tennessee for assistance in accessing non-shelter housing.**

Objective: To increase the number of families who are no longer living in homeless shelters by 2%.

Population: Families with children within the Homeless Population

Criterion: **4: Targeted Services to Homeless and Rural Populations**

Brief Name: **C&Y Homeless**

Indicator: Percentage of families with children who are in temporary or permanent housing.

Measure: % Numerator: Unduplicated # of families with children accessing non-shelter housing.
Denominator: Unduplicated # of families with children receiving homeless outreach services.

Sources of Information: C&Y Homeless Outreach Project Annual Report

Special Issues: Children's risk of experiencing behavioral, emotional, and/or substance abuse problems may increase with extended periods of homelessness.

Significance: Access to non-shelter housing options for homeless families with children, especially those with SED or at risk of SED, is more likely to promote child and family stabilization.

Goal 3: **To ensure an adequate enrollment of the C&Y priority population residing in rural areas.**

Objective: To enroll 50% of children and youth with SED residing in rural populations.

Population: Children and youth with SED, TennCare enrollees, living in rural areas

Criterion: **4: Targeted Services to Homeless and Rural Populations**

Brief Name: **Rural SED Enrolled**

Indicator: Number of TennCare enrolled children and youth with SED residing in rural counties.

Measure: % Numerator: The number of children in TennCare assessed as SED and residing in rural counties.

Denominator: The estimated prevalence of SED in Tennessee's rural counties.

Sources of Information: DMHDD, Office of Managed Care, Research & Analysis Group

Special Issues: The Denominator is based on 9% of the age 5-17 rural population according to the Tennessee Statistical Abstract 1994/95.

Significance: Assuring access to mental health services for youth with SED living in rural areas.

Goal 4: **To ensure that youth in the priority population living in rural areas access needed mental health services.**

Objective: To maintain service access to at least 90% of rural child and adolescent enrollees with a current priority population assessment.

Population: Children and youth with SED, TennCare enrollees, living in rural areas

Criterion: **4: Targeted Services to Homeless and Rural Populations**

Brief Name: **Rural SED Served**

Indicator: Number of children and adolescents with SED receiving mental health services as TennCare enrollees living in rural areas

Measure: % Numerator: Unduplicated # of rural county enrollees under eighteen receiving a mental health service

Denominator: Unduplicated # of rural county enrollees under eighteen with a current assessment of SED

Sources of Information: DMHDD, Office of Managed Care, Research & Analysis Group

Special Issues: Accessing mental health services in rural areas may be inhibited due to issues of transportation, stigma or parental unawareness of resources available.

Significance: Assuring mental health services for youth with SED living in rural areas.

FY04 STATE PLAN IMPLEMENTATION REPORT PERFORMANCE INDICATOR C&Y SED DATA TABLE

Criterion: 4: Targeted Services to Homeless and Rural Populations

	SFY 02 Actual	**SFY 03** Projected	**SFY 04** Objective Attain	**%**
Performance Indicator: **1. C&Y Referral**				
Value:	61%	N/A	↑ 2%	_____
IF Rate: Numerator	115	N/A		_____
and Denominator	189	N/A		_____
Performance Indicator: **2. C&Y Homeless**				
Value:	48%	N/A	↑ 2%	_____
IF Rate: Numerator	218	N/A		_____
and Denominator	452	N/A		_____
Performance Indicator: **3. Rural SED Enrolled***				
Value:	73.8%	N/A	70%	_____
IF Rate: Numerator	22,941	N/A		_____
and Denominator	31,069❶	N/A		_____
Performance Indicator: **3. Rural SED Served***				
Value:	42.5%	N/A	90% (or more)	_____
IF Rate: Numerator	9,754	N/A	_____	_____
and Denominator	22,941❷	N/A	_____	_____❸

❶ Based on 9% of Tennessee rural population ages 5-17.

❷ Unduplicated number of TennCare enrollees with SED in rural counties – no determination of current TPG assessment.

❸ Will be based on # of rural youth with current TPG assessment of SED.

* TennCare claims data processing may lag by several months; therefore, a full 12-months of data may not be included in total numbers.

Criterion 5
Management Systems

Financial Resources

(Please see Adult Criterion 5 on page 66.)

Staffing and Training for Providers

- DMHDD/DMHS

Staffing:

Despite an ongoing hiring freeze and a projected 200 employee layoff, DMHDD has adequate staff to conduct the business of the department, but limited ability to take on new responsibilities. Staff perform multiple departmental roles and must "pick-up" responsibilities as staff positions are eliminated or shifted and not replaced. The position of Director of Children and Youth Services was vacant for eight months; this position is expected to be filled on September 15, 2003. Like most states, Tennessee is experiencing a shortage of professional community staff, especially registered nurses. The availability of psychiatrists and psychologists with clinical expertise in the treatment of children and youth is especially critical.

Training:

In addition to routine networking opportunities, monitoring and technical assistance, DMHDD provides a variety of training related to implementation of grant-funded services to community providers, family and consumer groups and special grant recipients.

- DMHDD provides supplemental funds to support conferences by TVC and is a participant on the interagency committee for planning the annual Children's Health Summit.
- The RIP programs provide training as an essential element of the model - parent training of behavior management. Statewide training is provided to new resource coordinators at the Nashville location. RIP staff and statewide RIP technical assistance staff conduct training.
- BASIC programs staff receive intensive training at initial implementation and as staff turnover occurs. Technical assistance is available on request and is provided during site visits.
- The Tennessee Respite Network training curriculum for respite providers is offered several times per year or as requested. The network maintains specialized training curricula for problem issues. DMHDD participates in sponsoring an annual Tennessee Respite Conference.

- DMHDD participates in co-sponsoring an annual Youth Violence Prevention Conference.
- DMHDD provides information to consumers, family members, the public, mental health service providers, legislators, and other state agencies on the mental health service delivery system and how to access services.
- DMHDD provides on-going information and orientation about the mental health service delivery system to the SMHPC, RMHPCs, and the DPPC. These training activities assist members in their role of advising DMHDD of service need, availability, and access issues.
- Funding is provided by DMHDD to pay the cost of child care for parents or caretakers of children with SED to attend state and regional planning council meetings.
- Nashville Connection staff sponsor and assist in conducting training workshops on wraparound services and system of care planning, including the development of marketing tools. Staff also make presentations at conferences and meetings on the integrated services model.
- Child Care Consulting staff conduct a variety of events on early childhood education, mental health assessment and children's mental health needs.

Table 5.01 below details routine training activities that will be conducted by DMHDD C&Y Services staff during FY04.

TABLE 5.01 DMHDD Annual Routine Training Schedule

PROVIDER GROUP	FREQUENCY OF TRAINING
Homeless Outreach	Twice per year
BASIC	Twice per year
RIP	Four times per year
Planned Respite	Annually
Suicide Prevention Action Groups	Annually

➢ TennCare

Staffing:

The state contract with the medical and behavioral health organizations requires those entities to maintain an adequate provider base to provide services to individuals covered under the benefit plan. The BHO's outpatient network consists of around 1,000 credentialed and contracted individual and group providers (exclusive of CMHC staff), a small increase from FY02. As of April 2003, the network included the following providers of services for children and youth.

- 13 providers of 24-hour residential treatment at 14 locations
- 16 providers of inpatient psychiatric services at 16 locations
- 14 providers of inpatient substance abuse services at 15 locations
- 1 provider of crisis response services for 95 counties

Rural recruitment of psychiatrists, psychologists and other master's level professional staff continues to be a problem. The availability of trained child psychiatrists and psychologists is especially low. Professional staff and network shortages may impact timely access to services and increase waiting lists, causing more emergency admissions.

Stakeholders report unacceptable waits for services in some areas and are consistently aware of the difficulties in accessing child psychiatrists and/or psychologists. Telemedicine is utilized for service delivery by a limited number of agencies, and funding options for expanded use of this medium are being explored by DMHDD and the BHOs.

Training:

BHO consumer advisory staff provide on-going training and information sessions to inform providers, consumers, family members, and advocates about Tennessee's managed care system.

In order to improve and build upon the skills of providers delivering mental health services, TennCare requires BHOs to offer the following:

1) an educational plan for providers formulated with input from the BHO Advisory Board; (Boards must have minimum 51% family and consumer membership and consumers and family members must be included as trainers.)
2) cross-training of mental health and substance abuse providers;
3) mental health training for primary care providers; and
4) assurance that providers are appropriately licensed, certified, accredited, approved and/or meet DMHDD standards, whichever is appropriate.

Training Providers of Emergency Health Services

(Please see Adult Criterion 5 on page 69.)

Expenditure of 2004 Block Grant Allocation

DMHDD utilizes its Block Grant funding for the provision of non-clinically related mental health services for adults with SMI and children and youth with, or at risk of, SED. Services are designed to reduce the use of hospitalization; promote education, prevention, and early intervention; integrate services; and build a reliable community support service system that emphasizes empowerment, recovery, and normalization for individuals and families.

Currently, twelve private, not-for-profit CMHCs and two other community agencies receive federal mental health block grant funds to provide services to children and youth. Each contracted agency must provide services in accordance with a specific contract, budget, and scope of services. (Contract agencies may change or others may be added as service contracts are finalized.)

Approximately 33% of the CMHS Block Grant, or $2,576,100, will be allocated for children and youth services in accordance with Criterion 1, 2, 3, 4, and 5 in the following manner:

BASIC **$ 1,596,500**

- Project BASIC is an elementary school-based mental health early intervention and prevention service that works with children from kindergarten through third grade. Goals are to enhance awareness and capacity for response of school personnel to the mental health needs of children and to reduce the incidence of adolescent and adult mental health problems. Children with SED are identified and referred for mental health services. Funds support BASIC programs at forty-seven elementary school locations.

Mental Health/Primary Care Interface **$ 30,000**

- Centerstone will continue development of an integrated model for children and youth, particularly for children at risk or with SED. Scope of Services include aggressive outreach to parents of children and youth through age seventeen, monitoring screening tools to enhance early identification of behavioral, developmental and/or medical problems, providing parent advocacy, and conducting a variety of educational and training events for other behavioral and primary care providers.

Pediatric Liaison Services **$ 70,000**

- In an effort to increase the number of children and adolescents enrolled in TennCare who are receiving services and assure the appropriate assessment and services for children and youth with or at risk of SED, a pilot program of outreach to children and youth not currently being served was funded for Memphis/Shelby County. Outreach liaison staff will interface with and facilitate referrals from Shelby County pediatricians and primary care providers. Staff will provide assessments to identify children in need of mental health treatment services, facilitate referral to the appropriate community provider for services, and provide education about and referral to EPSDT assessments.

Early Childhood Network **$ 145,000**

- This is a collaborative effort on the local level to identify and address the mental health needs of preschool through third grade children through prevention and early intervention strategies. The effort is intended to provide a seamless and comprehensive system to identify and serve, at an early age, children in need of mental health services by networking all local agencies that work with this age group. Funding supports projects in two counties that currently have RIP, BASIC, and Day Care Consultation and have identified gaps in services.

Jason Foundation School Curriculum **$ 72,500**

- In response to the Surgeon General's Call to Action to Prevent Suicide Plan, one of Tennessee's strategies targets providing educational programs for youth that address suicide. The Jason Foundation offers a Triangle of Prevention approach for awareness and prevention of youth suicide. The Triangle of Prevention consists of programs that address

youth, parents, and teachers/educators in suicide awareness and prevention through educational programs and seminars.

NAMI-TN Parent Education **$ 72,500**

- "Visions for Tomorrow" is a program that provides education for families of children with SED, utilizing a train-the-trainer model. The goal of the program is to empower parents and guardians to become advocates for their children and to develop tools to help other families in a supportive, educational manner.

Planned Respite Services **$ 589,600**

- This is a program that provides respite services to families of children identified with serious emotional disturbance, or dually diagnosed with SED and mental retardation, who are ages two to fifteen. Respite consultants provide short-term respite and work with the family to identify long-range respite resources. Individualized family respite plans are developed with the family. The consultant enables families to develop community-based respite resources and utilize them effectively. Funding supports respite services in seven sites

Table 5.02 on page 111 details the proposed FY04 Block Grant contract amounts for C&Y services by agency and program.

TABLE 5.02 PROPOSED FY04 BLOCK GRANT CONTRACT AMOUNTS FOR C&Y SERVICES

CMHC	BASIC	PRIMARY CARE/PED LIAISON	EARLY CHILD NETWORK	JASON/ NAMI	RESPITE	TOTAL
Frontier	279,557	0	0	0	81,112	$360,669
Cherokee	70,028	0	0	0	0	$70,028
Ridgeview	40,016	0	0	0	81,112	$121,128
Volunteer	280,110	0	72,500	0	184,040	$536,650
Fortwood	40,016	0	0	0	0	$40,016
Centerstone	263,887	30,000	72,500	0	81,112	$447,499
Carey	120,048	0	0	0	0	$120,048
Pathways	120,047	0	0	0	0	$120,047
Quinco	222,727	0	0	0	81,112	$303,839
Professional Counseling	160,064	0	0	0	0	$160,064
Frayser	0	0	0	0	81,112	$81,112
Southeast	0	70,000	0	0	0	$70,000
OTHER AGENCY						
Jason Foundation	0	0	0	72,500	0	$72,500
NAMI TN	0	0	0	72,500	0	$72,500
TOTAL C&Y	**$1,596,500**	**$100,000**	**$ 145,000**	**$145,000**	**$589,600**	**$ 2,576,100**
					Total Adult	**$ 5,324,800**
					Total Both	**$ 7,900,900**
					Admin. 5%	**$ 415,751**
					TOTAL BG	**$ 8,316,651**

PERFORMANCE INDICATOR DESCRIPTIONS

Goal 1: **To ensure a fair proportion of Block Grant funding for early intervention and prevention services for children and youth.**

Objective: To maintain the range of funding for early intervention and prevention services at 25-30% of Block Grant funding.

Population: Children and Youth with SED, or at risk of SED

Criterion: **5: Management Systems**

Brief Name: **C&Y Allocation**

Indicator: Percentage of block grant funds being used for prevention and early intervention services.

Measure: % Numerator: amount to be allocated for prevention and early intervention services
Denominator: total amount of block grant funding minus administrative costs

Sources of Information: DMHDD Budget

Special Issues: Allocations based on continued ability to expend Block Grant funding for non-treatment services.

Significance: Children and youth under eighteen comprise nearly 25% of Tennessee's population. Prevention and early intervention services for children and youth are considered most important to avoid more serious emotional and/or behavioral problems.

Goal 2: **To ensure DMHDD funded programs and services are in compliance with contractual and service performance agreements.**

Objective: To maintain the number of monitored services meeting contract compliance to 95%.

Population: Agencies under contract with DMHDD, Division of Mental Health Services, to provide services for children and youth.

Criterion: **5: Management Systems**

Brief Name: **C&Y Service Compliance**

Indicator: Percentage of contracted programs and services that are in full compliance with DMHDD contract.

Measure: % Numerator: # of programs/services in full compliance
Denominator: # of contracted programs and services monitored during the previous state fiscal year

Sources of Information: Finance & Administration Compliance Report and Workpapers

Special Issues: While actual compliance monitoring is carried out by Finance & Administration staff, quarterly monitoring reports are submitted to DMHDD for review.

Significance: DMHDD is committed to the provision of quality services and programs.

Monitoring of contract agencies helps ensure quality services and is also a tool for providing technical assistance.

FY04 STATE PLAN IMPLEMENTATION REPORT PERFORMANCE INDICATOR C&Y SED DATA TABLE

Criterion: **5: Management Systems**

	SFY 02 Actual	**SFY 03** Projected	**SFY 04** Objective	**%** Attain
Performance Indicator: **1. C&Y Allocation**				
Value:	32%	N/A	25-30%	_____
IF Rate:				
Numerator	$2,423,262	N/A		_____
and				
Denominator	$7,548,100	N/A		_____
Performance Indicator: 2**. C&Y Service Compliance**				
Value:	N/A	N/A	95%	_____
IF Rate:				
Numerator		N/A		_____
and				
Denominator		N/A		_____

ABBREVIATIONS GLOSSARY

BADAS	-	Bureau of Alcohol & Drug Abuse Services
BASIC	-	Better Attitudes and Skills In Children
BHO	-	Behavioral Health Organization
BRIDGES	-	Building Recovery of Individual Dreams and Goals through Education and Support
C&Y	-	Children and Youth
CAB	-	Consumer Advisory Board
CHI	-	Creating Homes Initiative
CMHA	-	Community Mental Health Agency
CMHC	-	Community Mental Health Center
CMHS	-	Center for Mental Health Services
CMS	-	Center for Medicaid and Medicare Services
COD	-	Co-occurring Disorders (Mental Health and Substance Abuse)
CRG	-	Clinically Related Groups
DCS	-	Department of Children's Services
DDRN	-	Dual Diagnosis Recovery Network
DFA	-	Department of Finance and Administration
DIC	-	Drop-in Center
DMHDD	-	Department of Mental Health and Developmental Disabilities
DMHS	-	Division of Mental Health Services
DOC	-	Department of Correction
DOE	-	Department of Education
DOH	-	Department of Health
DPPC	-	Departmental Planning & Policy Council
DRA	-	Dual Recovery Anonymous
EPSDT	-	Early Periodic Screening, Diagnosis, and Treatment
FY	-	Fiscal Year
GAF	-	Global Assessment of Functioning
HUD	-	U.S. Department of Housing and Urban Development
IDEA	-	Individuals with Disabilities Education Act
IEP	-	Individualized Education Plan
IFSP	-	Individualized Family Service Plan
LMHI	-	Lakeshore Mental Health Institute
MBMHI	-	Moccasin Bend Mental Health Institute
MCO	-	Managed Care Organization
MMHI	-	Memphis Mental Health Institute
MOU	-	Memorandum of Understanding
MTMHI	-	Middle Tennessee Mental Health Institute
NAMHPAC	-	National Association of Mental Health Planning & Advisory Councils
NAMI-TN	-	National Alliance for the Mentally Ill, Tennessee
OCAA	-	Office of Consumer Affairs and Advocacy
OMC	-	Office of Managed Care
PATH	-	Projects for Assistance in the Transition from Homelessness
PL	-	Public Law

GLOSSARY (Continued)

RMHI	-	Regional Mental Health Institute
RMHPC	-	Regional Mental Health Planning Council
SAMHSA	-	Substance Abuse and Mental Health Services Administration
SED	-	Serious Emotional Disturbance
SMHPC	-	State Mental Health Planning Council
SMI	-	Seriously Mentally Ill
SPMI	-	Severely and/or Persistently Mentally Ill
SPOC	-	Service Planning and Oversight Committee
TAMHO	-	Tennessee Association of Mental Health Organizations
TCA	-	Tennessee Code Annotated
TCCY	-	Tennessee Commission on Children and Youth
TCM	-	TennCare Medicaid
TCPP	-	TennCare Partners Program
TCPR	-	TennCare Partners Program Roundtable
TCS	-	TennCare Standard
TMHCA	-	Tennessee Mental Health Consumers Association
TPG	-	Target Population Group
TTSP	-	Targeted Transitional Support Program
TVC	-	Tennessee Voices for Children
WMHI	-	Western Mental Health Institute